

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE NORTHERN DISTRICT OF OHIO
3 EASTERN DIVISION

4 IN RE: NATIONAL PRESCRIPTION :
 OPIATE LITIGATION : MDL No. 2804
5 _____ : Case No.
 : 1:17-md-2804
6 THIS DOCUMENT RELATES TO: :
 :
7 The County of Lake, Ohio v. : Hon. Dan A. Polster
 Purdue Pharma, LP, et al. :
8 Case No. 18-op-45032 :
 :
9 The County of Trumbull, Ohio :
 v. Purdue Pharma, LP, et al. :
10 Case No. 1:18-op-45079 :
 :
11 Track 3 Cases :
 _____ :

12
13 Friday, April 16, 2021
14 HIGHLY CONFIDENTIAL
 SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

15
16 Remote videotaped deposition of
17 EMILY MOONEY, conducted at the location of the witness
18 in Chardon, Ohio, commencing at 10:02 a.m., on the
19 above date, before Carol A. Kirk, Registered Merit
20 Reporter, Certified Shorthand Reporter, and Notary
21 Public.

22
23
 GOLKOW LITIGATION SERVICES
24 877.370.3377 ph | 917.591.5672 fax
 deps@golkow.com

1 R E M O T E A P P E A R A N C E S

2 - - -

3 On behalf of the Plaintiffs:

4 LEVIN PAPANTONIO THOMAS MITCHELL

RAFFERTY & PROCTOR P.A.

5 BY: JEFF GADDY, ESQUIRE

jgaddy@levinlaw.com

6 LAURA DUNNING, ESQUIRE

ldunning@levinlaw.com

7 316 South Baylen Street, Suite 600

Pensacola, Florida 32591

8 205-435-7000

9

On behalf of HBC Service Company:

10

MARCUS & SHAPIRA LLP

11 BY: MATTHEW R. MAZGAJ, ESQUIRE

mazgaj@marcus-shapira.com

12 DAVID ZWIER, ESQUIRE

zwier@marcus-shapira.com

13 SCOTT D. LIVINGSTON, ESQUIRE

livingston@marcus-shapira.com

14 One Oxford Center, 35th Floor

301 Grant Street

15 Pittsburgh, Pennsylvania 15219-6401

412-338-3345

16

17

18 ALSO PRESENT:

19 Jonathan Jaffe, It's-Your-Internet

Mike Kutys, Document Tech

20 Jeff Fleming, Videographer

21

22

23 - - -

24

1	INDEX TO EXAMINATION	
2	WITNESS	PAGE
3	EMILY MOONEY	
4	CROSS-EXAMINATION BY MR. GADDY	7
	REDIRECT EXAMINATION BY MR. MAZGAJ	321
5	RECROSS-EXAMINATION BY MR. GADDY	331
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		

1		INDEX TO EXHIBITS	
2	MOONEY	DESCRIPTION	PAGE
3	Exhibit 1	Document titled, "Chapter One, Introduction to Pharmacy,"	85
4		Bates-stamped HBC_MDL00190685 through 190876	
5			
6	Exhibit 2	Annual Performance Review for Emily K. Mooney, Bates-stamped	165
7		GE_TL00015154 through 15164	
8	Exhibit 3	Performance Appraisal - FY11, Bates-stamped GE_TL00015205	186
9		through 15208	
10	Exhibit 4	Employee evaluation, Bates-stamped GE_TL00015265	193
11		through 15270	
12	Exhibit 5	Giant Eagle Bonus 2015, Bates-stamped HBC_MDL00191127	198
13		and 191128	
14	Exhibit 6	Giant Eagle Bonus 2017, Bates-stamped HBC_MDL00191153	203
15		and 191154	
16	Exhibit 7	Giant Eagle Bonus 2020, Bates-stamped HBC_MDL00191155	206
17		and 191157	
18	Exhibit 8	PowerPoint titled, "Giant Eagle Pharmacy Welcome Workshop,"	208
19		Bates-stamped HBC_MDL00191099 through 191106	
20	Exhibit 9	Controlled Substance Dispensing Guideline, Bates-stamped	282
21		HBC_MDL00191292 through 191295	
22	Exhibit 10	E-mail from Mr. Miller, dated 12/4/2016, with attachment,	299
23		Bates-stamped HBC_MDL00059191 through 59269	
24			

1	INDEX TO EXHIBITS (CONT'D)		
2	MOONEY	DESCRIPTION	PAGE
3	Exhibit 11	Metrics reports Bates-stamped	304
		GE_TL00011878 through 12022	
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			

1

- - -

2

P R O C E E D I N G S

3

- - -

4

THE VIDEOGRAPHER: We are now on

5

the record. My name is Jeff Fleming.

6

I'm a videographer for Golkow Litigation

7

Services. Today's date is April 16,

8

2021. The time is 10:02 a.m.

9

This remote video deposition is

10

being held in the matter of National

11

Prescription Opiate Litigation in the

12

United States District Court, Northern

13

District of Ohio, Eastern Division. The

14

deponent is Emily Mooney.

15

All parties to this deposition are

16

appearing remotely and have agreed to

17

the witness being sworn in remotely.

18

Due to the nature of remote

19

reporting, please pause briefly before

20

speaking to ensure all parties are heard

21

completely.

22

All appearances will be noted on

23

the stenographic record, and the court

24

reporter is Carol Kirk and will now

1 swear in the witness.

2 - - -

3 EMILY MOONEY

4 being by me first duly sworn, as hereinafter
5 certified, deposes and says as follows:

6 CROSS-EXAMINATION

7 BY MR. GADDY:

8 Q. Good morning, Ms. Mooney. Could
9 you please state your name.

10 A. My name is Emily Mooney.

11 Q. And we had a chance to meet just a
12 moment ago, but my name is Jeff Gaddy. I'm a
13 lawyer down here in Florida, and I'm going to be
14 asking you some questions today.

15 Have you ever had your deposition
16 taken before?

17 A. I have not.

18 Q. Okay. Have you ever had an
19 opportunity to testify before, whether it's in
20 court or an administrative hearing or anything
21 like that?

22 A. No, I have not.

23 Q. Okay. I'm confident that your
24 attorney has kind of talked to you about ground

1 rules and things like that. But as we go
2 through today, I'm going to ask you some
3 questions, and if you could try to answer out
4 loud and answer verbally as opposed to shaking
5 or nodding your head and things like that, that
6 would help me, and that would also help the
7 court reporter take down your answers, okay?

8 A. Okay.

9 Q. And you understand that the oath
10 that you just gave is the same oath you would
11 give if you were actually sitting in a courtroom
12 in front of a judge and jury?

13 A. I do, yes.

14 Q. And there's the potential that
15 this testimony that you're giving today could be
16 played for the jury just as if you were in --
17 sitting in the courtroom.

18 Do you have that understanding as
19 well?

20 A. I do, yes.

21 Q. I don't know how long we're going
22 to go today. It will definitely be several
23 hours. I hope it's not all day. I also have
24 childcare issues today. So I have some of the

1 same situations going on that you might have.

2 But if at any point during today
3 you want to take a break, whether it's food,
4 lunch, restroom, whatever, just let me know and
5 I'm happy to do that, okay?

6 A. Yes.

7 Q. Okay. So outside of the context
8 of testimony, have you ever had the opportunity
9 to provide an affidavit, a sworn statement,
10 anything like that in relation to your work at
11 Giant Eagle, whether it's a statement to law
12 enforcement or a statement for a Board of
13 Pharmacy hearing or any of those types of
14 things?

15 MR. MAZGAJ: Object to form.

16 A. Not that I'm aware of.

17 Q. And what city and county do you
18 live in?

19 A. I live in Chardon, Ohio, in Geauga
20 County.

21 Q. Okay. And how long have you lived
22 in that city and county?

23 A. Probably 10 to 12 years.

24 Q. Okay. And you anticipate being in

1 that area for the next year or so?

2 A. Yes.

3 Q. Okay. And if we needed to get in
4 contact with you, the address that we had the
5 materials delivered for the deposition today
6 would be a good way to get in touch with you?

7 A. Yes.

8 MR. MAZGAJ: Through her attorney,
9 but yes.

10 Q. Ms. Mooney, what did you do to
11 prepare for this deposition today?

12 A. I spoke with my attorney a couple
13 times. We went over some things.

14 Q. Okay. When you say you spoke with
15 your attorney, do you mean -- are you referring
16 to Matt, who is here with you today?

17 A. I am, yes.

18 Q. And how many times did you have a
19 chance to speak with Matt?

20 A. Probably three or four times.

21 Q. And when did that process start?
22 About how long ago?

23 A. Oh, jeez. I think I was contacted
24 back in February, and I spoke with someone else

1 at the law office. I don't recall his name.

2 And he just got some information about me and
3 the store.

4 MR. MAZGAJ: Ms. Mooney, I'm just
5 going to caution you not to discuss
6 anything that we talked about during
7 those sessions. It's protected by the
8 attorney-client privilege. So you can
9 talk about how many times and when, but
10 none of the substance, please.

11 THE WITNESS: Right. Okay.

12 A. So I spoke with this other guy
13 initially. Then Matt got a hold of me over
14 the -- another call, and then -- and then the
15 last -- or two days this week I spoke with him
16 over Zoom.

17 Q. Okay. About how many hours do you
18 think you spent speaking with Matt to get ready
19 for this?

20 A. Probably 16, 17 hours.

21 Q. Okay. Outside of Matt or this
22 other attorney that you said you spoke to
23 initially, have you talked with anybody else to
24 help get ready for this deposition?

1 A. No.

2 Q. Okay. Have you talked to any of
3 your -- any of your coworkers about the
4 deposition?

5 A. Only that I had to do a
6 deposition. Nothing else.

7 Q. Okay. Have you had an opportunity
8 to review or read any other depositions that
9 have been taken in this case to help you get
10 ready?

11 A. No, I have not.

12 Q. Now, you work for Giant Eagle,
13 correct?

14 A. I do.

15 Q. Okay. And how long have you
16 worked for Giant Eagle?

17 A. Since 2005. Yes. So 16 years.

18 Q. Okay. Have you been a pharmacist
19 all of those 16 years?

20 A. No.

21 Q. Okay. When did you become a
22 pharmacist?

23 A. In 2009.

24 Q. Okay. Have you ever been a

1 pharmacist for anybody other than Giant Eagle?

2 A. I have not.

3 Q. Okay. Have you ever worked for
4 any -- in any capacity, have you worked for any
5 pharmacies other than Giant Eagle?

6 A. Not a retail pharmacy. I did work
7 in a hospital as a PRN for a little while, but
8 that's it.

9 Q. Okay. What time period was that?

10 A. In '09, right when I got out of
11 school.

12 Q. What is a PRN?

13 A. As needed. Sorry. So they would
14 call me if they had someone call off. I wasn't
15 on the schedule.

16 Q. Okay. And that was as a
17 pharmacist?

18 A. Yes.

19 Q. Okay. And how long did you do
20 that?

21 A. About a year.

22 Q. Okay. And help me understand
23 that. So that's a pharmacy within a hospital?

24 A. Yes.

1 Q. Okay. So --

2 A. An inpatient pharmacy.

3 Q. You cut out there for a second.

4 Could you say that again?

5 A. Sorry. It was an inpatient
6 pharmacy.

7 Q. Okay. So the customer base that
8 you were filling prescriptions for were patients
9 at the hospital?

10 A. Correct.

11 Q. People weren't coming in off the
12 street with prescriptions?

13 A. No.

14 Q. Now, how was it that you started
15 working at Giant Eagle back in 2005?

16 A. I was interested in the medical
17 field. I was going to school for pharmacy. So
18 I thought being a technician would be the next
19 step.

20 Q. Okay. What year did you graduate
21 high school?

22 A. In '03.

23 Q. Okay. So at the time you started
24 at Giant Eagle, were you already in college?

1 A. Uh-huh.

2 Q. You have to say yes or no.

3 A. Oh, yes. I'm sorry.

4 Q. No, that's fine.

5 Okay. So in -- when you decided

6 to start working at Giant Eagle, you already

7 knew that you wanted to be a pharmacist?

8 A. Correct. Yes.

9 Q. Okay. And how did you select

10 Giant Eagle over the other retail or independent

11 pharmacies that are out there in the

12 communities?

13 A. At that time I knew a family

14 friend was an HR manager at the time for a few

15 Giant Eagles. So she told me I should apply,

16 and got my application.

17 Q. Okay. And did you apply to any

18 other pharmacies or just the Giant Eagle where

19 you had a family friend who was in HR?

20 A. Just Giant Eagle.

21 Q. Okay. And you said at the time

22 that you started working at Giant Eagle, that

23 you knew you wanted to be a pharmacist.

24 A. I knew I wanted to be a

1 pharmacist, yes.

2 Q. Okay. Tell me a little bit more
3 about that. I mean, how did you decide that you
4 wanted to be a pharmacist and kind of what
5 motivated that career path for you.

6 A. I have a mother that is very
7 driven. No, I've always been interested in the
8 medical field. I took a lot of science classes
9 in high school. I was a science nerd, for lack
10 of a better word. And, yes, my mother thought
11 that pharmacy would be a good choice. So I went
12 that way.

13 Q. Okay. And I assume you're happy
14 you did?

15 A. I am, yes.

16 Q. Okay. Good.

17 So let me -- I'm going to go back
18 into your Giant Eagle career and employment
19 there in just a minute, but let me step back and
20 kind of start and do a little bit of a kind of
21 educational background.

22 So you said you graduated high
23 school in '03. Did you immediately go to
24 college?

1 A. Yes, I did.

2 Q. Okay. And where did you -- where
3 did you go to college?

4 A. The University of Toledo.

5 Q. And what did you major in?

6 A. Pharmacy.

7 Q. Tell me about how that works as
8 far as -- I mean, do you do your first couple of
9 years with kind of your general education and
10 the last one or two or three years as pharmacy
11 specific? How does that work?

12 A. The University of Toledo has a --
13 I don't know if they still do, but when I went,
14 they had a track program, a six-year program.
15 The first two years is prerequisites. The last
16 four years are you're in the pharmacy school at
17 that point. You would apply to get into that.
18 But it is -- you still get your bachelor's
19 degree in that track, as well as the PharmD at
20 the end.

21 Q. Okay. So did you get both the
22 undergraduate degree and the PharmD?

23 A. Yes.

24 Q. Okay. And so it's four years to

1 get the bachelor's degree and then an extra two
2 years to get the PharmD?

3 A. Right.

4 Q. Okay. In your mind is there a
5 difference between the first four years and the
6 last two? I mean, if somebody asked you about
7 pharmacy school, would you tell them about the
8 whole six years or just the last two?

9 A. It's actually the last four of the
10 track is in the pharmacy school. So, yes, the
11 first two years are different than the last four
12 years. You're in the program during those last
13 four years. The first two years is getting into
14 the program.

15 Q. Okay. Are there any other majors
16 that come out of the pharmacy school other than
17 a major in pharmacy?

18 A. Yes. Yes, they have other
19 schools.

20 Q. Can you give me some examples of
21 some of the others?

22 A. They have a law school. There's a
23 medical campus. I don't -- I'm not sure if the
24 medical campus was a part of it yet when I was

1 there, but I know it is now. Education,
2 business.

3 Q. I think I asked a bad question.
4 What I was getting at is, within
5 the pharmacy school, are there other degrees
6 that you can come out with? So is there, like,
7 a pharmacy tech program, or are there other
8 degrees or programs within the pharmacy school
9 other than just getting your PharmD?

10 A. Yes. I know there's a few, but
11 the only one I know for sure is you can be,
12 like, a pharmaceutical rep, so then you take
13 business courses. After applying to the
14 pharmacy school, a lot of -- if they didn't get
15 into pharmacy -- the actual pharmacy school,
16 some people went that route where they did more
17 of the business end and became a pharmaceutical
18 rep. I know there's a few others, but I can't
19 remember them offhand.

20 Q. Okay. I want to ask you just kind
21 of some general -- or start with some general
22 and then maybe a few specific questions about
23 some of the classes that you would have taken in
24 pharmacy school, so just talking about those

1 last four years.

2 Can you just kind of give me in
3 your own words kind of a general overview of the
4 types of classes that you took there at Toledo?

5 A. Sure. The first few years in the
6 pharmacy school we did more general
7 pharmacology, the different drugs for different
8 systems, treating different things. The last
9 few years we did more focused specialties, so we
10 did pediatrics, oncology, cardiology,
11 pulmonology, GI, renal. We took a law course.

12 Those are what I can remember
13 offhand.

14 Q. Okay. Do you -- you mentioned
15 some of the specific classes or specific areas.

16 Do you recall whether or not you
17 had any specific classes that were just devoted
18 to controlled substances?

19 A. I think that would be in the law
20 course. We had a whole year of law, so that
21 comes up quite a bit in that, so ...

22 Q. Okay. No. That's a good point.
23 I'm going to ask you about the law course in
24 just a second, but I'm talking more on the

1 pharmacology side. So you talked about, you
2 know, oncology, cardiology, pulmonology, renal.
3 Any classes that kind of were on the class of
4 drugs of controlled substance outside of the law
5 context?

6 A. Yeah, that would be in the
7 pharmacology course. So, I mean, we took two
8 years of pharmacology. So we learned about
9 those there.

10 Q. Okay. What does pharmacology
11 mean?

12 A. It's the study of the drugs. So
13 we learned how they worked, how -- the
14 administration, the dosing, how they're absorbed
15 by the body, the kinetics, a whole -- we went by
16 class through the drugs. So it's a thorough
17 review.

18 Q. Okay. Did you have any classes on
19 pain management?

20 A. Not a class. Just --

21 Q. Okay. Did you have any classes on
22 the treatment or the appropriate treatment for
23 conditions like chronic pain?

24 A. We did go over that in

1 pharmacology, so -- on how to treat a patient
2 for pain. Yes, that was in the pharmacology
3 class.

4 Q. Okay. Tell me what you remember
5 from the pharmacology class about how to treat a
6 patient for chronic pain.

7 MR. MAZGAJ: Objection to form.

8 A. It's more the drugs related and
9 what drugs are used for immediate pain,
10 long-term treatment of pain, extended release
11 forms to -- that someone would take immediately
12 to help treat it.

13 So we don't -- it was more on the
14 dosing and how those medications are given, how
15 we would see them as a pharmacist to determine
16 that it's written correctly and dosed correctly.

17 Q. Okay. And tell me what you mean
18 when you -- and what you learned when it came to
19 the proper treatment and dosing as it related to
20 chronic pain patients.

21 A. I'm not sure I understand what
22 you're asking. A chronic pain patient would be
23 on a long-acting opiate theoretically. So we
24 learned about those drugs and how they would be

1 dosed.

2 Q. Okay. And that's what I'm asking,
3 is if you were taught that a chronic pain
4 patient would be on long-acting opiates -- what
5 did you learn about dosing, length of treatment,
6 those types of things?

7 A. I mean, the dosing for long-term
8 treatment of pain is different for different
9 medications. We can -- I mean, it's different
10 for each medication, so I don't -- I don't
11 really know how to go into that, per se. But
12 patients can be on a long-term treatment. And
13 pain is very hard to treat, and they need to be
14 treated. They may need to be treated long term,
15 so ...

16 Q. Okay. And those concepts were
17 taught to you all the way as far back as
18 pharmacy school at Toledo?

19 A. Right.

20 Q. Okay. Is there anything else that
21 you remember from pharmacy school in the
22 education process about treatment of chronic
23 pain patients, anything else that you remember?

24 MR. MAZGAJ: Objection to form.

1 A. I don't remember anything other
2 than what I've told you.

3 Q. Okay. You mentioned the pharmacy
4 law class. Tell me a little bit about that
5 class and what it covered.

6 A. Well, we do have to take a board
7 exam, two exams, to become a pharmacist, one of
8 them being Ohio and federal law. So we learn
9 federal laws in regards to the practice of
10 pharmacy, and then also the state's laws, and we
11 do whatever is more stringent. Usually Ohio law
12 is more stringent than the federal, so we learn
13 that difference so that we can take the Ohio law
14 exam.

15 Q. Okay.

16 A. It's in preparation for that.

17 Q. I'm sorry. I missed the last
18 thing you said. Oh, preparation --

19 A. Preparing us for that exam.

20 Q. Okay. Do you recall any education
21 in pharmacy school regarding the identification
22 of red flags related to diversion as it relates
23 to filling controlled substance prescriptions?

24 MR. MAZGAJ: Objection to form.

1 A. I'm not sure about that in
2 pharmacy school. I can't remember anything like
3 that.

4 Q. Okay. Okay. When did you
5 graduate pharmacy school?

6 A. 2009.

7 Q. Okay. And you mentioned there
8 were some boards you had to take. Did you take
9 those in 2009?

10 A. I did.

11 Q. Okay. And since you're a
12 pharmacist, I presume you passed your boards?

13 A. I did, yes.

14 Q. Okay. And did you -- when did you
15 start working at Giant Eagle as a pharmacist?

16 A. Right away, once I passed my
17 boards. Right away.

18 Q. Okay. Let me kind of, again, take
19 a step back, and what I want you to kind of do
20 is give me -- I didn't get a CV or a resumé for
21 you, so I'm hoping that you can kind of give me
22 a general overview of your career at Giant Eagle
23 as far as the different positions that you had
24 and how they've changed over time.

1 And so if you don't mind starting
2 in 2005. And whether it was during school or
3 during the summer or whatever, just kind of let
4 me know what you were doing. And then I'll come
5 back and probably ask some specific questions
6 about some of the different jobs.

7 Can you do that?

8 A. Absolutely. So in 2005, in May of
9 2005, I got hired as a technician at the Chardon
10 Giant Eagle. So for the summer, I worked there
11 in this area, in Geauga County.

12 I went back to school in August
13 and transferred from this area out to Lucas
14 County. They had two Giant Eagles in the Toledo
15 area. So I transferred to one of those stores.
16 And I worked at their Central Avenue location.

17 At this point in 2005, I would
18 have gotten my intern license. So I became an
19 intern while I was at that store. So I interned
20 throughout the rest of pharmacy school at the
21 Central Avenue store in Toledo.

22 Once -- my last year in pharmacy
23 school, so that would have been '08, the summer
24 of '08, to when I graduated, I had moved back

1 home, which is this area, for my pharmacy
2 rotations. So I was -- each month I would be at
3 a different location to complete the
4 prerequisites to graduate.

5 But during that time, I still
6 worked in Lake County at a former Giant Eagle
7 that isn't there anymore in Mentor, Ohio. So I
8 worked there throughout the year as I was
9 completing my rotations.

10 Once I graduated and while I was
11 studying for my boards, I became a graduate
12 intern, and I floated to any store that needed
13 me at that point on the east side of Cleveland.

14 And then once I got my license, I
15 started as a floater pharmacist primarily
16 working in the Mentor-on-the-Lake Giant Eagle,
17 and I worked there -- really, I worked there for
18 a little while -- I would say at least a year --
19 before I got the manager position at the
20 Painesville store in 2012.

21 I've been at the Painesville
22 location since then as the manager.

23 Q. Okay. So you've been at one store
24 since 2012?

1 A. Correct.

2 Q. Okay. All right. So you used --
3 it sounds like you held several different
4 positions. I heard tech. I heard intern. I
5 heard graduate intern, floater, and manager.

6 Did I get them all?

7 A. Right.

8 Q. Okay. So I'm going to go one by
9 one and just kind of -- what I'm -- just so you
10 know what I'm getting at here, is I'm trying to
11 understand the differences between the positions
12 within Giant Eagle.

13 So let's just start at when you
14 were a tech in May of 2005. Kind of give me an
15 explanation or an overview of what your role and
16 responsibility was as a pharmacy tech.

17 A. A pharmacy tech is there to assist
18 the pharmacist. I would -- I did data entry on
19 prescriptions. I rung out customers, helped
20 find -- customers find product on the shelves,
21 counted the prescriptions out for the
22 pharmacist. I did insurance billing. Those are
23 a few things.

24 Q. Okay. Any other primary task of a

1 pharmacy tech that you can think of? I get that
2 there may be other smaller things, but any other
3 primary job responsibilities of a pharmacy tech
4 that you haven't told us about?

5 A. No. I think that covers most of
6 them. Yes.

7 Q. Okay. Today, would that
8 description generally be the same as it was in
9 2005?

10 A. Yes, yes. I don't believe
11 anything has changed for the role of a tech.

12 Q. Okay. The next thing that I'm
13 going to ask about each of these positions is --
14 obviously, as I'm sure you're aware, this case
15 deals with controlled substances and opiates in
16 particular. So I'm going to ask you whether or
17 not there was anything specific to those
18 positions, any specific rules or policies with
19 those positions that would relate to opiates.

20 So, for example, you just told me
21 as a tech, you might count medication, right?

22 A. Uh-huh.

23 Q. Okay. So one of the things that
24 I'd be interested in is if there was a rule or a

1 procedure that you weren't allowed to count
2 oxycodone pills, for example.

3 So with that kind of background
4 and understanding, were there any particular
5 rules or regulations or policies in place at
6 Giant Eagle regarding controlled substances and
7 opiates in particular that impacted what you did
8 as a pharmacy tech?

9 MR. MAZGAJ: Objection to form.

10 A. There are a lot of policies at
11 Giant Eagle. We have the controlled substance
12 policy. There are quite a few policies that we
13 have in regards to filling medications in
14 general.

15 I mean, there's extra things. A
16 technician when filling a prescription for a
17 controlled medication. The medication is --
18 depending on the class, any controlled
19 medication is double counted by the technician
20 and their initials are placed on the label.
21 That's one example.

22 For a C-II medication, the
23 technicians will count the medication, double
24 count the medication, and then also back count

1 the stock bottle before giving it to the
2 pharmacist. And then the pharmacist would also
3 double count the controlled medication or the
4 C-II.

5 So there are a lot of things in
6 place to make sure that the patient gets the
7 correct amount, especially when it comes to the
8 controlled medications.

9 Q. Okay. Were there any limitations
10 on pharmacy techs when it came to Schedule II
11 controlled substances as far as data entry or
12 filling, or, you know, handing the prescription
13 to the customer? Any restrictions as far as the
14 pharmacy tech doing any of those things?

15 A. No. They can count the
16 medication. They can't retrieve the -- a C-II
17 medication is locked in the safe and only a
18 pharmacist can get that for them, but they are
19 permitted to count them. I mean, other than
20 that, they don't -- they don't check in the
21 orders for that. Only a pharmacist does that.

22 So that would be the only time
23 that they were handling those medications.

24 Q. Okay. So when it comes to

1 Schedule II prescriptions, only a pharmacist can
2 retrieve the medication; is that right?

3 A. Yes.

4 Q. Okay. And you said only a
5 pharmacist can check it in?

6 A. Yes. If the order comes in, those
7 are bagged in separate totes, and only the
8 pharmacist can check those in to our inventory
9 and put them into the safe.

10 Q. Gotcha. When they're delivered to
11 the -- when the bottles are delivered to the
12 store.

13 A. Yes.

14 Q. Okay. So that's -- you don't mean
15 check in like check in a prescription. You mean
16 check in like a delivery of bottles?

17 A. Yes, yes.

18 Q. Okay.

19 A. The actual prescription, a
20 technician can take --

21 Q. Okay.

22 A. -- from the patient.

23 Q. So a technician can take a
24 patient, a technician can enter the data for a

1 C-II prescription, a technician can count a C-II
2 prescription, and a technician can hand a C-II
3 prescription to a patient after a pharmacist has
4 made the decision that the prescription should
5 be filled.

6 Is that all correct?

7 MR. MAZGAJ: Objection to form.

8 A. Yes, that's correct.

9 Q. Okay. The next position that you
10 told me about that you had was as an intern,
11 correct?

12 A. Yes.

13 Q. Okay. Tell me the difference
14 between an intern and a tech.

15 A. The intern has a few more
16 responsibilities, one being the fact that they
17 do have the ability to counsel a patient under
18 direct supervision of a pharmacist. Technicians
19 cannot do that. They cannot make
20 recommendations. An intern can. So that is
21 one.

22 They can take prescriptions from a
23 doctor. If the doctor is calling in the
24 prescription, they can take that prescription

1 down. If we're transferring a prescription to
2 another pharmacy, the intern can do that as well
3 as long as it's not a controlled medication.
4 Interns are not allowed to do that in the State
5 of Ohio.

6 Let's see. That's -- those are
7 the three big things.

8 Oh, and then now they can immunize
9 under the direct supervision of a pharmacist as
10 well, so ...

11 Q. Okay. So it sounds like the same
12 restrictions regarding controlled substances for
13 a tech also apply to an intern; is that right?

14 A. Right. Yes.

15 Q. Okay. And you mentioned Ohio law.
16 Are these kind of roles and responsibilities for
17 the intern -- from your understanding, are they
18 governed by Ohio law, or are they -- or is this
19 Giant Eagle policy?

20 A. Ohio law.

21 Q. Okay. So Ohio law has these
22 definitions for what the techs and the interns
23 are and are not allowed to do?

24 MR. MAZGAJ: Objection; calls for

1 a legal conclusion.

2 A. Definitely for an intern. I'm not
3 familiar with the law for techs.

4 Q. Okay. That's fine.

5 The next position you mentioned
6 was a graduate intern?

7 A. Right.

8 Q. Okay. Can you tell me the
9 difference between a graduate intern and the
10 prior two positions of tech and intern?

11 A. Basically you're graduated, so you
12 have your degree, but you don't have your
13 license yet, but there's no difference -- you're
14 still an intern, so there's no difference in
15 what you can do.

16 Q. Okay. So you still can't get
17 controlled Schedule II drugs out of the safe,
18 right?

19 A. Correct.

20 Q. Okay. But you can still accept a
21 Schedule II prescription, you can enter the data
22 for a Schedule II prescription, you can count a
23 Schedule II prescription, and you can hand a
24 Schedule II prescription to a customer after a

1 pharmacist has determined that it should be
2 filled, correct?

3 A. Yes.

4 MR. MAZGAJ: Object to form.

5 Q. Okay. And I presume you could
6 still counsel a patient under the supervision of
7 a pharmacist as a graduate intern, right?

8 A. Yes.

9 Q. And I think you said that once you
10 became licensed, your first role was as a
11 floater?

12 A. Yes, I was a floater.

13 Q. Okay. Tell me what that term
14 means in the context of Giant Eagle.

15 A. Sure. It means that I had a
16 regional scheduler, and I'd float to stores that
17 pharmacists were on vacation or there were holes
18 in the schedule. So I just worked at different
19 stores. There was no set schedule for me.

20 Q. Okay. How many different stores
21 were kind of within the possibility for you to
22 work at while you were a floater?

23 A. I'm not sure of the number. When
24 I signed on with Giant Eagle, I signed on for a

1 region of Northeast Ohio, so the east side of
2 Cleveland. So I'm not sure of the amount of
3 stores that I went to or that are in that area.

4 Q. Okay. Can you give me a ballpark
5 as far as is it less than five, less than ten,
6 less than fifty, understanding that it's an
7 estimate?

8 A. Probably 15 -- 15 to 20 maybe,
9 different stores.

10 Q. And over what period of time did
11 you float and have the potential to work at
12 these 15 to 20 stores?

13 MR. MAZGAJ: Objection to form.

14 A. From 2009 up until 2012.

15 Q. Okay. I know you're a manager
16 now, but does Giant Eagle still use the role of
17 floater?

18 A. Yes, they do.

19 Q. Okay. And do you sometimes still
20 have floaters come and work in your store in
21 Painesville?

22 A. Yes.

23 Q. Okay. When you were a floater
24 from '09 to '12, what would you say the furthest

1 was that you ever had to travel to go to a store
2 to work?

3 A. Forty-five minutes, maybe an hour.

4 Q. Okay. As a floater, was there any
5 type of information packet or orientation packet
6 that would have been store specific that you
7 would have been presented on on going to one of
8 these approximately 15 to 20 stores to work at
9 over this period of time?

10 A. No. We -- Giant Eagle has
11 policies in place that if -- that makes it
12 easier for floaters to go to different stores
13 because we all work under the same policies.

14 So other than maybe placing a box
15 in a different location -- I mean, that box is
16 going to be in that pharmacy. So we know where
17 to look, where to find things. That's usually
18 not an issue.

19 Q. Okay. So as far as the layout of
20 the pharmacy, the computer system within the
21 pharmacy, all of that type of thing is pretty
22 standardized across all the Giant Eagles; is
23 that fair?

24 A. Yes.

1 Q. Okay. So let me ask a little bit
2 of a different question.

3 You've been a manager at the
4 Painesville pharmacy since 2012?

5 A. Yes.

6 Q. Okay. I would imagine that while
7 you probably have new and unique customers who
8 come in from time to time, you also probably
9 have a set of customers that you know or
10 recognize when they come in the pharmacy. Is
11 that generally fair?

12 A. Yes.

13 Q. And I would imagine there's
14 patients that you could probably think of off
15 the top of your head that you've helped them for
16 several years and you know the types of
17 medications that they're on, the types of
18 conditions that are being treated, and you know
19 those patients fairly well.

20 Is that fair?

21 A. Yes.

22 Q. Okay. And I also would imagine
23 there's probably -- you probably have some sense
24 of familiarity with some of the physicians that

1 commonly have prescriptions filled at your
2 store; is that true?

3 A. Yes. I'm in contact with
4 physicians quite a bit. Yes.

5 Q. Okay. So knowing that that's how
6 it works for you when you've been a manager at
7 this one store in Painesville since 2012 -- so
8 that's kind of the context that I'm asking about
9 for while you were a floater.

10 So when you floated to these
11 approximately 15 to 20 stores from '09 to 2012,
12 was there any type of orientation material or
13 introductory material that would kind of help
14 you become oriented with the patient or
15 physician base for a particular Giant Eagle
16 store?

17 MR. MAZGAJ: Objection to form.

18 A. There's nothing like a packet, but
19 that's what you have colleagues for. The
20 technicians are a great resource, and then the
21 other pharmacists that you work with. So if I
22 did have questions, they are a great resource
23 for that.

24 Q. Okay. So you're telling me that

1 you have colleagues within the store that you
2 can ask questions to, but there was no
3 orientation material, information packet, that
4 would be presented and available to floating
5 pharmacists at the different stores, correct?

6 A. I -- I don't believe you can have
7 something like that because of HIPAA laws. You
8 can't just make a packet of patients. So, no,
9 we don't have that.

10 Q. Is there a store number for the
11 store in Painesville?

12 A. 6377.

13 Q. Are there any other -- I guess
14 that's the only store you've worked at since
15 2012, right?

16 A. For the most part, yes. If I had
17 to help out a friend and pick up a shift, then
18 so be it, but ...

19 Q. Okay. Did you go straight from
20 being a floater to being a manager?

21 A. I did. Yes.

22 Q. Okay. So is there another role in
23 there that you kind of jumped over as far as
24 whether it's a staff pharmacist or something

1 like that?

2 A. I worked -- I told you I worked at
3 Mentor-on-the-Lake -- the Mentor-on-the-Lake
4 Giant Eagle for an extended period. So I was
5 technically a floater. That was my job title.
6 But in all respects, I was a staff pharmacist
7 there. I covered a hole for a very long-term
8 period, definitely over a year. I'm not sure of
9 the whole time, but I was in the same store for
10 over a year.

11 Q. Okay. Do you remember what that
12 store number is?

13 A. 1217.

14 Q. And are there any differences in
15 the duties of a floating pharmacist and a staff
16 pharmacist, which it sounds like essentially
17 that was the role you were filling at 1217?

18 A. No. Essentially, no. I mean, I
19 was more involved in scheduling when I was
20 there. Anything more I could do to help with
21 the running of that store's day-to-day, I was
22 more involved in. As a floater, you just go in
23 for the day. There I did help out more,
24 particularly with tech schedules and things like

1 that. But no real difference when it came to
2 what you did as a pharmacist.

3 Q. Okay. And now as a manager, can
4 you kind of give me an overview of the
5 differences in your -- the kind of scope of your
6 duties and responsibilities as a manager as
7 opposed to the staff pharmacist or the floater
8 role?

9 A. Sure. I mean, in -- obviously my
10 job as a pharmacist is the same wherever I am.
11 But as a manager, obviously I was more involved
12 in the day-to-day, staffing, hiring of
13 technicians, scheduling. I make the
14 pharmacists' schedule, technicians' schedules,
15 making sure that all of my staff is up to date
16 on their CEs and training. That's in my job
17 title. More of the managerial aspect of the
18 business, so ...

19 Q. I'm going to have some more
20 questions about that in a minute, but how do you
21 communicate within Giant Eagle? And what I'm
22 getting at there is, you know, communications
23 maybe -- I understand that there's PDLs,
24 pharmacy district leader.

1 A. Right.

2 Q. You know, and I guess my
3 understanding is there's a PDL that supervises a
4 region. Is that -- do I have that right?

5 A. Yes.

6 Q. And who's your PDL in Painesville?

7 A. Currently it's Christine Yee.

8 Q. Okay. Who was it before her?

9 A. Angela Garofalo.

10 Q. Okay. Anybody before her?

11 A. Let's see. She's been there for a
12 while. At one point, Adrienne Anthony for a
13 little while.

14 Q. Okay. Who would you consider your
15 supervisor?

16 A. Christine Yee.

17 Q. So the PDL is the supervisor of
18 the managing pharmacist?

19 A. Right, of the pharmacists. Yes.

20 Q. Of all the pharmacists?

21 A. Uh-huh.

22 Q. Okay. I'm sorry. You have to say
23 yes or no.

24 A. Yes. Sorry.

1 Q. Okay. Are you the supervisor of
2 the staff pharmacists within your stores?

3 A. No. Their direct supervisor would
4 be my boss as well.

5 Q. Okay. If a decision needed to be
6 made to terminate a staff pharmacist, is that a
7 decision that you make or the PDL makes?

8 A. The PDL.

9 Q. Okay. Okay. So my original
10 question was, how do you communicate within
11 Giant Eagle, and what I'm getting at is, how
12 would you communicate with your PDL or even
13 further up the chain to corporate. Is there an
14 e-mail system, an instant messenger type system.

15 Obviously outside of verbal or
16 phone communication, how does that happen?

17 MR. MAZGAJ: Objection to form.

18 A. There is an e-mail system with
19 Giant Eagle. That's my primary way of
20 communicating with anyone.

21 Q. Okay. And explain to me how that
22 works. Because I know there's a lot of folks
23 that work behind the pharmacy counter as far as
24 techs, interns, pharmacists. Does everybody

1 have their own e-mail account? I know that some
2 entities seem to have a store e-mail account.
3 Explain to me how that works.

4 A. I do have my own e-mail account
5 with Giant Eagle. For the most part, we use the
6 store's e-mail for communication. So, yes, our
7 pharmacy has its own e-mail.

8 Q. Okay. Let me ask you this: Do
9 you ever use a personal e-mail account to
10 communicate with Giant Eagle employees regarding
11 work-related issues?

12 A. Yes.

13 Q. Okay. What types of issues do you
14 use your -- and when I say "personal," I'm
15 talking a Gmail or a Yahoo or something like
16 that.

17 Are you with me there?

18 A. Oh, no. I use my Giant Eagle
19 e-mail.

20 Q. Okay. Okay. Yeah. So do you
21 have a personal e-mail account, whether it's a
22 Gmail or Yahoo or whatever it is?

23 A. Yes, I do.

24 Q. Okay. Do you use that e-mail for

1 any communications with Giant Eagle employees
2 for work-related issues?

3 A. Not that I'm aware.

4 Q. Okay. And then you have an
5 individual Giant Eagle account that's just for
6 Emily Mooney, correct?

7 A. Right.

8 Q. Okay. What is that e-mail
9 address?

10 A. Emily.mooney@gianteagle.com.

11 Q. Okay. Do all pharmacists have an
12 individual e-mail account?

13 A. I believe so. Yes.

14 Q. Okay. What about pharmacy techs?

15 A. I don't think so. No.

16 Q. What about interns?

17 A. I don't know that. I haven't had
18 an intern in a while. I don't know that.

19 Q. Okay. And when you have to
20 communicate with, whether it's your PDL or
21 somebody else, within Giant Eagle that you can't
22 speak to personally in the store, which e-mail
23 account would you primarily use?

24 A. I primarily use the store's

1 e-mail.

2 Q. Okay. And what is the store's
3 e-mail account?

4 A. I think it's rx.manager, something
5 with 6377 in it, at giganteagle.com. I always
6 have to look it up if I'm giving it out. It's a
7 dash I think in there somewhere.

8 Q. Okay. That's fine. Who all has
9 the ability to use that e-mail account to send
10 e-mails?

11 A. Everybody in the pharmacy
12 potentially.

13 Q. Okay. And I guess anybody in the
14 pharmacy can read e-mails that come into that
15 account; is that right?

16 A. Yes.

17 Q. Okay. Can you give me a couple of
18 examples of the types of e-mails that you would
19 send from that account?

20 MR. MAZGAJ: Objection to form.

21 A. Okay. Staffing. I usually -- I
22 have many e-mails to our recruiter, hiring. I
23 can -- I send e-mails to our -- my PDL if I have
24 a question. A lot of them are COVID related

1 right now.

2 What else? Turning in hours to
3 HR, asking for help during the day if we need
4 help with checking or from our central facility.
5 I mean, day-to-day operations.

6 Q. Okay. And can you give me some
7 examples of the types of e-mails other than
8 responses to questions and things like that?
9 But is that store e-mail account how you receive
10 communications from corporate about policies,
11 procedures, programs, things like that?

12 A. Yes.

13 Q. Okay. Can you give me just some
14 general examples of those types of
15 communications that you would receive through
16 that store e-mail account from up the chain at
17 corporate?

18 A. Usually --

19 MR. MAZGAJ: Object to form.

20 A. -- we have -- I don't know. I
21 mean, if there's a policy that comes out, they
22 would send it that way. That's how we
23 communicate or how our PDL would communicate to
24 all of us if there's a meeting, a conference

1 call.

2 The president of the, like, Giant
3 Eagle store, like, she'll give an update of what
4 stores -- how the stores are doing, just general
5 information. That's about it.

6 Q. Okay. Now, I kind of want to
7 understand the same couple of concepts as it
8 relates to your individual e-mail account at
9 Giant Eagle.

10 When would you choose to use your
11 individual Giant Eagle e-mail account as opposed
12 to store e-mail account?

13 A. The things that get sent to my
14 individual account -- definitely hiring related,
15 because I have to usually click a link, and I'm
16 the only one that can do the hiring. So that
17 sort of thing goes to my personal e-mail. But
18 then they usually send an e-mail to the store as
19 well to let me know that it's there. But that's
20 really about it.

21 Q. Outside of hiring decisions, is
22 there anything that you use your personal e-mail
23 for to communicate up the chain to your PDL or
24 anybody else at corporate?

1 A. My Giant Eagle e-mail?

2 Q. Yes. Sorry. Your individual
3 e-mail at Giant Eagle. Thank you.

4 A. Right. No, not that I recall
5 making.

6 MR. MAZGAJ: Hey, Jeff, we're
7 about --

8 A. That's what I can remember.

9 MR. MAZGAJ: Oh, sorry. Go ahead.
10 I was going to say, we're an hour
11 in, and I promised Emily I'd check in to
12 make sure she's okay.

13 THE WITNESS: I'm good. I'm good.
14 I could use -- well, I could use a quick
15 break, I guess.

16 MR. GADDY: Yeah, I'm out of
17 coffee, so that's fine.

18 THE WITNESS: Okay.

19 MR. MAZGAJ: Perfect.

20 THE VIDEOGRAPHER: Off the record,
21 11:00 a.m.

22 (Recess taken.)

23 THE VIDEOGRAPHER: On the record,
24 11:07 a.m.

1 BY MR. GADDY:

2 Q. Do you have a -- you know what I
3 mean when I say intranet?

4 A. No.

5 Q. Like here at my law firm, we have
6 an intranet where I can go on and I can see a
7 directory of everybody who works here and their
8 extension to get to their desk, and there's,
9 like, a little HR link where I can go and look
10 at -- you know, request time off and those type
11 of -- do you have, like, an online Giant Eagle
12 only intranet?

13 A. Yes. We use a Workday system.
14 So, yes, I can see hierarchy and names that way.
15 I've never really used it for that. But, yes,
16 it is there.

17 Q. Okay. What types of things are on
18 that intranet that you do use in your kind of
19 daily job, if anything?

20 A. Hiring goes through that.
21 Typically that's what I use it most for right
22 now. Team -- team reviews, pay related.

23 I'm trying to think what else is
24 on there. Our e-learning, so any of the

1 required learning that we have to do for the
2 year is there. That's what I use it most for.

3 Q. Okay. Do you know whether or not
4 policies and procedures are stored on the
5 intranet there?

6 A. We have another learning -- or
7 another site on our home page. I don't -- I
8 don't know. GE Central, I think. And there's a
9 lot of folders for policies, procedures. Our
10 incident reporting is there.

11 Q. Okay. Is that something -- the
12 policies and procedures that would be stored on
13 that GE Central or whatever it's called, is that
14 something that all of the pharmacists have
15 access to?

16 A. Yes. Everybody has access to
17 that.

18 Q. Okay. Is that something that
19 you've ever had to access as far as going on and
20 looking at a policy and procedure?

21 Do you ever recall ever having to
22 do that?

23 A. Yes. So Giant Eagle requires us
24 to go over policies at quarterly CQI meetings,

1 which is basically a time when all of the
2 pharmacy can get together and go over -- we go
3 over policies. We go over any incidents, any
4 new procedures, any -- those would be happening
5 at quarterly meetings, but we do go over the
6 policies -- certain policies. We pick a couple
7 here and there.

8 We get communication every couple
9 weeks from another person in corporate that
10 sends policies to review or if there's any
11 changes in policy that need to be reviewed at
12 that time.

13 We usually then just put them up
14 in the pharmacy so that the employees can read
15 them as necessary and then sign off that we read
16 them, so ...

17 Q. Okay. So as the pharmacy manager,
18 is that something that kind of falls under your
19 purview? If there's a direction from corporate
20 that "We have a new XYZ policy, everybody needs
21 to read it and acknowledge it," that it's kind
22 of your job to make sure that gets done?

23 A. Yes.

24 Q. Okay. It sounds like you said the

1 standard protocol for that would be to print it
2 out, put it somewhere, and make sure that
3 everybody looks at it?

4 A. Right.

5 MR. MAZGAJ: Objection.

6 A. Yeah, we have something that we
7 hang it in the pharmacy. We have a board that
8 we can hang it on. A lot of them, though, we
9 just have a counter space that we do that most
10 people look at then and sign it, and then they
11 get filed in the pharmacy.

12 Q. Is there any type of
13 classification of Giant Eagle stores based on
14 size, volume, busyness, anything like that?

15 MR. MAZGAJ: Objection to form.

16 A. I don't believe so. There's
17 nothing that classifies a store as being any
18 different.

19 Q. Let me ask you a couple questions
20 about scheduling and staffing of the pharmacy.

21 At one point in time, you
22 mentioned having a regional scheduler when you
23 were a floater, and then I think you also said
24 that you're involved with scheduling of your own

1 pharmacy.

2 So I guess let's start with your
3 own pharmacy. Who dictates the staffing levels
4 at your pharmacy in Painesville that you're the
5 manager of?

6 A. I don't -- I mean, in terms of
7 hours, we have a number, like a labor forecast,
8 that is a baseline, but I don't -- I don't know
9 where that number exactly comes from, but we do
10 have a baseline.

11 Q. Okay. How many pharmacists work
12 at a time in the Painesville store?

13 A. I have three -- there's three of
14 us total in the pharmacy of pharmacists at Giant
15 Eagle in Painesville. We work four 10s. So we
16 do have overlap between two of us. During
17 weekdays between 11:00 and 6:30, there's two
18 pharmacists.

19 Q. Okay. What time does the pharmacy
20 open?

21 A. We open at 9:00 Monday through
22 Friday and close at 9:00.

23 Q. Okay. So from Monday to Friday,
24 there's one pharmacist on duty from 9:00 a.m. to

1 11:00 a.m. and from 6:30 p.m. to 9:00 p.m., and
2 two pharmacists on duty for that time in the
3 middle?

4 A. Right.

5 Q. Okay. What about on the weekends?

6 A. Weekends it's just one pharmacist.
7 We're open 9:00 to 6:00 on Saturdays, 9:00 to
8 5:00 on Sundays.

9 Q. And it's just one pharmacist on
10 duty for that entire time?

11 A. Correct.

12 Q. Okay. Who decided -- who made the
13 decision that there should only be one
14 pharmacist from 9:00 to 11:00, two from 11:00 to
15 6:30, and one from 6:30 to 9:00 during the
16 weeks? Was that a decision that you made or was
17 that, you know, kind of given down to you from
18 your PDL or somebody else from corporate as far
19 as what the staffing needed to be?

20 A. We get a guide -- a guideline, a
21 suggested schedule, from corporate -- or we have
22 in the past -- but I determine that schedule.

23 Q. Okay. Is the schedule that you've
24 implemented, is it the one that was suggested by

1 corporate for Painesville?

2 A. It's pretty close. Yes.

3 Q. Okay. If you were to decide that,
4 you know, Saturdays are pretty hectic and it's
5 tough for one pharmacy to handle the workload
6 and you decided that you wanted a second
7 pharmacist to be working on Saturday, what would
8 be the process to get that done? Could you just
9 tell one of the other pharmacists they needed to
10 work that second Saturday, or is that something
11 that you'd have to run up the chain through a
12 PDL or someone else at corporate?

13 MR. MAZGAJ: Objection to form.

14 A. I imagine I can make that
15 decision. I wouldn't. But, yes, I can make
16 that decision.

17 Q. Okay. Have you ever had to raise
18 with your PDL or with anybody at corporate
19 issues related to staffing as far as needing
20 more pharmacists?

21 A. No.

22 Q. How many -- okay. So you said
23 your pharmacists work four 10s, so each of
24 those -- each of those days, a pharmacist is

1 working a 10-hour shift; is that right?

2 A. For the most part. Sundays are
3 only an eight-hour day and Saturdays are nine.
4 So we just make up those hours during the week
5 as it works out. So, yes, between 10- and a
6 12-hour shift, depending on how the pharmacist
7 wants to break it up.

8 Q. And are you the one that is making
9 the decision about which pharmacists are working
10 which days and which shifts?

11 A. Yes. I make the pharmacists'
12 schedule, yes.

13 Q. Okay. And how does it work if,
14 for example, a pharmacist is out for a week on
15 vacation? Is that when a floater comes into
16 play?

17 A. Yes.

18 Q. Okay. How does that work? Do you
19 let a regional scheduler know, or how do you get
20 a floater?

21 A. Yes. Our vacations we have to
22 plan out a year or more in advance. So we
23 submit our vacations to the scheduler so that
24 she can make sure that it's split up evenly

1 throughout the year. So the scheduler knows
2 when we will be going on vacation. She usually
3 e-mails the store, asks us our needs and what
4 shifts, and then I just submit those to her.

5 Q. Okay. Do you have a regular
6 floater that comes into your store, or does it
7 change pretty regularly?

8 A. It changes. I mean, most of the
9 floaters, I know who they are, but there's no
10 designated floater for my store.

11 Q. What is kind of the break and
12 lunch schedule for pharmacists?

13 A. We don't -- Giant Eagle doesn't
14 have a lunch break. We don't close the pharmacy
15 for any reason. We do have overlap, though,
16 during those periods. So we usually take a
17 lunch, each of us, during -- sometime during
18 that overlap, about 20 minutes or so to eat and
19 come back.

20 Q. Okay. Are there any other breaks
21 that are permitted for the pharmacists
22 throughout the day other than the 20 minutes
23 that they may get for lunch?

24 A. No. I mean, if they -- if we

1 needed to go -- or, you know, if we need a
2 break, we need to go to the restroom, things
3 like that, we can go at any point. But this is
4 something that, you know, is what we're used to.
5 I don't feel like I need anything more than
6 that.

7 Q. I want to kind of ask the same
8 series of questions about pharmacy techs.

9 Are you in charge of scheduling
10 for them also?

11 A. I am, yes.

12 Q. Okay. Let me just kind of start
13 global.

14 How many pharmacy techs work at
15 the Painesville store, period?

16 A. I honestly -- I don't have an
17 exact number. I would say around ten at a time.

18 Q. Okay. I'm just asking how many
19 are currently on the payroll right now.

20 A. Let's see. I would say eight, and
21 then I have two -- three on leave.

22 Q. Okay. And is that -- is that
23 fairly normal, about eight to ten pharmacy techs
24 for your store? Is that low or high?

1 A. It's normal. I mean, it can go up
2 or down depending on the availabilities of my
3 technicians, if I need to hire more.

4 Q. Okay. How many technicians work
5 at a time?

6 A. We have three techs that start the
7 day, two to end. In the middle of the day, we
8 probably have four to five in the middle of the
9 day overlapping, depending on the day.
10 Weekends, a little less. I only have three
11 techs on the weekends.

12 Q. As far as the other two -- so you
13 said there's three pharmacists at the store, so
14 I assume that's you and two others?

15 A. Correct.

16 Q. Okay. How long have those other
17 two been with you?

18 A. Lorene is probably -- I don't know
19 exact dates. Probably five years or so. And
20 then Matt, two or -- two to three, I would say.

21 Q. Okay. Is there a time of day or
22 time of the week that's busier than other times
23 at the pharmacy?

24 A. Yes. Mondays are busy usually all

1 day. We do the most scripts on Mondays. Other
2 days it just kind of depends. Usually Friday
3 mornings are also very busy because doctors'
4 offices close usually earlier on Fridays.

5 That's about it.

6 Q. Can you give me kind of a general
7 description of the neighborhood or the community
8 that your pharmacy is located in.

9 A. Sure. We work -- Giant Eagle is
10 located in a township but pretty close to
11 Painesville City. So we do have a lot of
12 doctors' offices in the area. There's a
13 hospital pretty close by, a couple Urgent Cares.
14 We --

15 Is that what you were looking for,
16 just what's in the area?

17 Q. Yeah, yeah. And then if you're
18 able to kind of give a general description of
19 the customer base or the population. Is it, you
20 know, a working class neighborhood or more of a
21 white collar area? Just kind of your general
22 impression, however you would describe it.

23 A. In general, it's working class.
24 It's -- we have a -- it's located in -- pretty

1 close to a smaller city, but we have a lot of
2 patients that come in from, like, rural areas
3 because there's not really a whole lot in one
4 area, I guess. I don't know. About 25 minutes
5 in one direction, there's not a whole lot going
6 on there.

7 Q. Okay. Are there other pharmacies
8 in the area?

9 A. Yes. There are quite a few. CVS,
10 Walgreens. Our closest, Rite Aid. There's a
11 Drug Mart pretty close. Those -- I don't think
12 I'm forgetting anything. No. Those are really
13 the biggest ones and closest to us, so ...

14 Q. Do you know any of the pharmacists
15 that work at any of those other pharmacies?

16 A. Personally, no. I've spoken with
17 a few when we transfer prescriptions, but I
18 don't know any of them.

19 Q. Okay. Other than transferring
20 prescriptions, are there any other reasons that
21 you can think of that you've had to talk to
22 pharmacists at any of those other pharmacies?

23 A. I mean, that's -- that's usually
24 the biggest reason right now that I can think

1 of. But, I mean, we would call them if we have
2 questions about patients.

3 A lot of times we'll get a
4 prescription with a stamp from another pharmacy
5 on it. So if that comes up, I'll usually call
6 the other pharmacy to see why they didn't
7 actually fill that prescription there.

8 Another reason would be to get
9 patient info if -- or if they didn't accept
10 their insurance at that pharmacy, we would call
11 and get the prescription or get insurance
12 information, things like that.

13 Q. Okay. You said a prescription
14 with a stamp on it. What kind of stamp?

15 A. So I'm not sure about what other
16 pharmacies do, but my -- at Giant Eagle, any
17 time a hard copy prescription gets brought to
18 the pharmacy, we're required to stamp the
19 prescription, which prompts us to ask for date
20 of birth and allergies. That's one of our
21 policies. But a lot of pharmacies have similar
22 things to that. So that clues me in that
23 they -- a patient had brought their prescription
24 to another pharmacy. And if I see that, I

1 usually want to know why. So I will call the
2 pharmacy and ask them.

3 Q. Okay. Can you tell me another
4 pharmacy that you know uses a stamp system that
5 you've seen before and it's made you call?

6 A. I can't tell you -- I mean, I
7 think they all do in some form, but I can't tell
8 you for certain, no.

9 Q. Okay. Do you remember the last
10 time that you called a pharmacy -- another
11 pharmacy because you saw some indication that a
12 prescription had been taken to a different
13 pharmacy and that pharmacy had not filled the
14 prescription?

15 MR. MAZGAJ: Objection to form.

16 A. I can't recall an exact time.
17 Hard copy prescriptions are just not as common
18 right now. A lot of doctors in the area have
19 moved to electronic prescribing, so we don't
20 really see a lot of those as much, so ...

21 Q. Okay. Do you remember any
22 specific occasion where you received a hard copy
23 prescription and saw that it had been taken
24 somewhere else and not filled and you called the

1 other pharmacist to ask about that?

2 A. I mean, I know I have --

3 MR. MAZGAJ: Objection.

4 Emily, just a second.

5 Objection; asked and answered.

6 A. I know I do that, but I can't
7 recall a certain time or instance that I've done
8 that.

9 Q. Okay. Can you recall any -- can
10 you recall whether or not you've ever called and
11 talked to a pharmacist at another local store
12 about filling an opiate prescription?

13 A. Yes.

14 Q. Okay. When is the last time you
15 remember doing that?

16 A. I don't know. I mean, I do -- I
17 do it pretty -- I mean, it probably has been a
18 little while only because, like I said, we have
19 electronic prescribing, so -- and we have OARRS
20 reporting, which I check every time I check a
21 controlled prescription.

22 So for the most part, I don't need
23 to call -- I don't need to call pharmacies as
24 much as I used to because that information is

1 available to me. And, like I said, every
2 prescription for a control that I check, I check
3 the OARRS report. So I can see where that
4 prescription was filled, so --

5 Q. Let me ask the question a
6 different way. So I'm not limiting it to hard
7 copy prescriptions. I'm asking about any
8 prescription now.

9 When is the last time you recall
10 calling a pharmacist at another store regarding
11 an opiate prescription?

12 MR. MAZGAJ: Objection; asked and
13 answered.

14 A. I mean, I call pharmacies all the
15 time to transfer prescriptions, so I don't --
16 no, I can't recall transferring an opiate. I
17 don't know an exact time. So, I mean, I do -- I
18 talk to pharmacies daily. I can't remember if
19 it was an opiate or not.

20 Q. Okay. Well, let me see if I can
21 ask the question differently, because I'm not
22 asking about transfers.

23 So when is the last time that you
24 recall talking to a person at another pharmacy

1 about whether or not a prescription for an
2 opiate should be filled for a patient?

3 A. Like I said, I don't need -- OARRS
4 gives me the ability to see the information that
5 I would call and ask for, or I used to have to
6 call and ask for all the time. So I really
7 don't remember doing that. I don't have to do
8 that with OARRS being readily available.

9 So I don't remember the last time
10 that I had to do that.

11 Q. Okay.

12 A. I just don't.

13 Q. It's safe to say it's been -- I
14 mean, OARRS has been around for a long time,
15 right?

16 A. Right.

17 MR. MAZGAJ: Objection to form.

18 Q. Okay. So safe to say it's been --
19 would it be safe to say that it's been years
20 since you've called another pharmacist to ask
21 them about whether or not you should fill an
22 opiate prescription for a particular patient
23 because you relied on OARRS or other resources
24 that you had available?

1 MR. MAZGAJ: Objection; misstates
2 testimony.

3 A. Yeah. No, I don't -- I know it
4 hasn't been years, but I don't -- I don't
5 recall.

6 Q. Okay. With what frequency -- what
7 period of time -- so for what period of time
8 have you not needed to call other stores to ask
9 about whether or not an opiate prescription
10 should have been filled because you could rely
11 on OARRS?

12 MR. MAZGAJ: Objection; assumes
13 facts not in evidence.

14 A. I mean, every time I check a
15 prescription for a controlled medication, being
16 an opiate or not, I check OARRS for that
17 patient. So, I mean, as long as it's been
18 readily available to me. I don't know a
19 timeline exactly.

20 Q. Okay. Let me try to explain to
21 you what I'm looking for here because I think
22 maybe we're talking past each other.

23 What I'm trying to figure out is
24 whether or not you -- whether or not calling

1 pharmacists at other local stores about whether
2 or not you should fill a prescription for an --
3 an opiate prescription for a patient -- I'm
4 trying to figure out whether or not that's
5 something you do. And what I've heard is that
6 you've said maybe it's something you used to do,
7 but you really don't have to do it anymore
8 because of OARRS.

9 And so I'm trying to get a
10 timeline from back when you became a pharmacist
11 back in 2009 through today, was there a period
12 of time in which you would call other local
13 stores about whether -- you know, to ask
14 questions to determine whether or not to fill an
15 opioid prescription for a customer who has
16 walked into your store, or if that was not
17 something you did and you relied on the OARRS
18 database that's available through the State of
19 Ohio.

20 So with that background, let me
21 start again and ask a new question, okay?

22 A. Okay.

23 Q. So was there ever a period of time
24 while you were a pharmacist that it was a

1 practice of yours to call pharmacists at other
2 local stores to help you make a decision about
3 whether or not to fill an opiate prescription
4 for a customer in your store?

5 MR. MAZGAJ: I'm going to object
6 to the colloquy as a misrepresentation
7 of prior testimony.

8 A. I think I already told you that I
9 do call other stores. I mean, I gave the
10 example about when it had a stamp on it from
11 another pharmacy. That's when -- and what would
12 prompt me to call another store.

13 So, yes, in the period of my
14 practice from whenever I started pharmacy to
15 now, I have called pharmacies multiple times in
16 order to figure out where they're filling
17 prescriptions, if there's an issue with a
18 prescription. That is what I had to do.

19 I also said that once OARRS became
20 more readily available, it was much easier to
21 get that information off of OARRS instead of
22 calling the pharmacies as much. It has lessened
23 over time because of that resource that we have.

24 Q. Okay. You said that it started to

1 lessen when OARRS became more readily available.
2 Generally speaking, when is that time period?
3 That's all -- I'm trying to build a timeline
4 here.

5 So when did OARRS become more
6 readily available, to use your language --

7 A. Right.

8 Q. -- to where you didn't need to
9 call the stores?

10 A. I don't know exactly when OARRS
11 came about. I believe somewhere around 2013.
12 But then in -- 2016 I think is when it was put
13 into the Ohio Administrative Code about how, you
14 know, we need to use this resource, and it was
15 put into our computer system.

16 So, like I said, every
17 prescription that I check for control is -- I
18 can -- I can automatically check OARRS through
19 my computer system.

20 Before that, I would log in on my
21 own and I had my own login. I would have it up
22 while I was checking prescriptions and just
23 toggle back and forth.

24 If I checked a prescription for a

1 control, controlled med, I would input the data
2 myself. It took longer, but that was and is my
3 process. It is -- it is a part of my process
4 with every prescription.

5 Q. When you were calling stores to
6 help you make a determination about whether or
7 not you should fill an opiate prescription for a
8 patient who presented it, how often were you
9 having to call stores? Not for transfers, not
10 for blood pressure medication or anything else
11 like that, but for opiate prescriptions, how
12 often -- when you were calling stores, how often
13 would you have to do that?

14 MR. MAZGAJ: Objection to form.

15 A. I mean, I would say every day.
16 Sometimes multiple times a day. It just
17 depends. It depended on the prescriptions.

18 Q. You're saying that every day or
19 multiple times a day, you would have to call
20 other stores to help you make a decision about
21 whether or not to fill an opioid prescription?

22 MR. MAZGAJ: Objection;

23 misrepresents testimony.

24 A. Sometimes I -- yes. It depends on

1 the day, like I said. It depends on the
2 prescription. Like I also said, there were a
3 lot more hard copy prescriptions for controls
4 years ago, and now the push to electronic
5 prescribing has lessened that as well.

6 So, yes, at one point, I'm sure I
7 was every day calling other pharmacies. But
8 that's a part of my job, to do my due diligence.
9 If I see something like that on a prescription,
10 I will absolutely call.

11 Q. About how many opiate
12 prescriptions do you see in your pharmacy on a
13 daily basis?

14 MR. MAZGAJ: Objection; calls for
15 speculation.

16 A. I don't know the number. I don't.

17 Q. Okay. Can you give me your best
18 estimate knowing that it's an approximation?

19 A. I don't. I really don't know. I
20 can't put a number to it. I mean, we fill a lot
21 of prescriptions in a day, so I don't know.

22 Q. Okay. Do you have the ability to
23 run or pull reports from your dispensing system
24 to look at the number of prescriptions of

1 different types of drugs that you fill, you
2 know, a day, a week, a month, those types of
3 things?

4 A. Yes. We have the ability to run
5 reports.

6 Q. Okay. Is that something that
7 you've ever done, run a report to see how many
8 opioid prescriptions your pharmacy has filled
9 over any particular time period?

10 A. I don't really -- I'm sure I've
11 done it, but I don't -- it's not something we
12 would normally do. We would need a reason, I
13 guess, to -- I don't know why I would run a
14 report like that. So I couldn't tell you how to
15 do it. I know I could get it, but ...

16 Q. But you don't know that you've
17 ever done that?

18 A. No. I mean, I can run -- I've run
19 a movement report if I have a question about
20 certain drugs. We take multiple inventories,
21 especially of our C-II prescriptions. We do
22 monthly audits.

23 So it's not uncommon to run a drug
24 movement report to make sure that -- as a double

1 check for counts. But that's probably the only
2 report I really use when it comes to something
3 like that.

4 Q. You mentioned earlier that there
5 were several doctors' offices in the area around
6 the pharmacy, correct?

7 A. Yes.

8 Q. Can you give us kind of an
9 overview of the types of practices around -- in
10 the area around where your pharmacy is located?

11 A. I mean, I'm sure you could find
12 any practitioner in the area, multiple
13 specialties. Like I said, there's a hospital
14 right down the street. Urgent Cares. I mean, I
15 don't think there's anything that we don't have
16 around the pharmacy in regards to certain
17 specialties.

18 Q. Are you aware of whether or not
19 there's any pain clinics in the area around your
20 pharmacy?

21 A. Yes. There's -- I'm not -- I know
22 there's one pain clinic down the road, for sure.
23 I don't know whose it is. I just have passed it
24 before. But I know there's a couple more in the

1 area as well now.

2 Q. Are there any particular
3 physicians that you can tell us would be the
4 ones that you fill a large amount or large
5 percentage of opioid prescriptions for?

6 MR. MAZGAJ: Objection to form.

7 A. Well, there are a few pain
8 clinics, like I said. Dr. Pahr, Dr. Mikhail.
9 There's a Dr. Zielinski now too. Those are the
10 ones I can think of off the top of my head right
11 now.

12 Q. Okay. Are there any other
13 physicians that you can think of that you see
14 frequently writing prescriptions for opiates?

15 MR. MAZGAJ: Objection to form.

16 A. Like a general practitioner? Is
17 that --

18 Q. I'm just asking for anybody that
19 comes to mind to you that you feel like you see
20 a decent amount or a large amount of opiate
21 prescriptions for.

22 A. Right.

23 MR. MAZGAJ: Objection to form.

24 A. Dr. Koussa is one. In the past,

1 probably Dr. Hanahan, but he doesn't write so
2 much anymore. But those are the two that would
3 come to mind.

4 Q. Okay. I'm going to ask you about
5 a couple of other folks and ask you if you're
6 familiar with them or if you've heard of them.

7 A. Sure.

8 Q. A Dr. Matthew Keum?

9 A. Keum? Is it --

10 Q. It's K-e-u-m.

11 A. Oh, Keum. Yes.

12 Q. Okay. And what's his specialty?

13 A. I think he's a general internal
14 medicine. I'm not sure, but I think so.

15 Q. What about a Jerome Yokiell?

16 A. I've -- yeah, I've heard of that
17 doctor.

18 Q. Okay. What's his specialty?

19 A. I'm not sure.

20 Q. What about a Ronald Casselberry?

21 A. No.

22 Q. A Hyo Kim?

23 A. Yes.

24 Q. And what's their specialty?

1 A. I'm not sure.

2 Q. Of the physicians that you've
3 referenced that you're familiar with as far as a
4 high level of opiate prescribing, are there any
5 of those that you have had the occasion to speak
6 with their office regarding an opioid
7 prescription that they've written?

8 MR. MAZGAJ: Objection; misstates
9 prior testimony.

10 A. Yes. I've talk to doctors'
11 offices quite frequently regarding their opiate
12 prescriptions.

13 Q. Okay. I may or may not have some
14 more questions about that.

15 Can you kind of pick one or your
16 most recent conversation with one of these
17 physicians or their offices regarding an opiate
18 prescription, and obviously without revealing
19 any personal information, just kind of give me
20 an overview of that conversation.

21 A. Okay. I mean, the most recent, it
22 wasn't -- you want one with one of these doctors
23 exactly? Or is it just something I can -- that
24 comes to mind.

1 Q. Just give me -- the most recent
2 one is fine.

3 A. Okay. So recently, in the last
4 week, a doctor wrote a prescription for an
5 opiate along with a benzodiazepine, and the
6 patient has been on both of those before
7 previously, and then she recently wrote a
8 prescription for Soma.

9 So any time a Soma prescription is
10 prescribed, I call the doctor. There's a lot of
11 evidence showing that it's just not effective
12 and increases the risk of dependence. So we --
13 it's practice for all the pharmacists, at least
14 at my store, that we will call the doctor
15 anytime a Soma prescription is prescribed.

16 She wrote the prescription for a
17 month of it. We called to double-check and
18 asked why they were prescribing it for that
19 long. And the doctor actually ended up changing
20 it to a week supply.

21 So in the short term, we filled
22 that medication, but that was a dialogue that
23 went between us and the doctor's office.

24 So that's just one example.

1 Q. Okay. Thanks. That's helpful.

2 So did the phone call regarding
3 the Soma have anything to do with the fact that
4 there was also a prescription for an opiate and
5 a benzo, or was it just the Soma alone that made
6 you call?

7 A. Both. Anytime Soma is prescribed,
8 we usually call. But, yes, it's usually -- it
9 definitely was more of a reason to call, because
10 they're also on those other two medications.

11 Q. Okay. Were these -- kind of
12 sticking on the topic of physicians, when you're
13 filling a prescription that's been written by a
14 specific physician, I'm trying to get an
15 understanding of what information you would have
16 about that physician within your system at Giant
17 Eagle.

18 So, for example, would you know
19 that physician's specialty?

20 A. No, we wouldn't. In our system,
21 no.

22 Q. Okay. I mean, obviously if you're
23 familiar with the doctor, you might know what
24 their particular specialty is, but that's not

1 tracked within the software of Giant Eagle?

2 A. No, it is not.

3 Q. Okay. Would you have an
4 understanding of the number of prescriptions
5 that doctor had written that had been filled at
6 your store?

7 A. Okay. I'm sorry. Clarify that
8 for me, the number that they've written?

9 Q. Correct, that had been filled at
10 your particular store.

11 A. I -- I don't know. I'm sure
12 there's a report maybe for that.

13 Q. Okay.

14 A. But I have never run anything like
15 that.

16 Q. Okay. And so I guess the same
17 answer for whether or not you have the
18 information regarding the number of
19 prescriptions that that physician has written
20 that have been filled at all Giant Eagle
21 pharmacies?

22 MR. MAZGAJ: Objection to form.

23 A. I don't know.

24 Q. Okay. And that's not information

1 that you've ever had at your hands when filling
2 a prescription, correct?

3 A. No.

4 MR. MAZGAJ: Objection to form.

5 Q. What about any -- is there any
6 information or any display within the Giant
7 Eagle dispensing system or dispensing software
8 that gives you any information regarding any
9 disciplinary action against a physician?

10 MR. MAZGAJ: Objection to form.

11 A. So we can look that up. I mean,
12 we can look up if there is any legal action
13 against a physician. Usually our -- someone at
14 corporate would probably let us know that as
15 well, but I can't recall something like that
16 happening. But, I mean, we can, and I have,
17 looked up on the Medical Board site if there was
18 anything against any doctors.

19 Q. Is it a part of the standard fill
20 practice to always run a search on a physician
21 and determine whether or not there's any
22 disciplinary action?

23 A. There is no standard or law
24 stating that I need to do that.

1 Q. Okay. I mean, obviously you could
2 jump on Google just like I could or anybody else
3 could and Google, you know, Dr. John Doe and see
4 whether or not they have anything, but my
5 question is a little bit different.

6 What I'm -- I'm asking whether or
7 not there's anything within the dispensing
8 software, the dispensing platform that you use
9 at Giant Eagle, that provides an alert or
10 information that there's any disciplinary action
11 pending or adjudicated against a physician.

12 A. Not that I'm aware of. I don't
13 know, I mean, why that would be important to
14 that prescription, you know, as I'm checking it.

15 I mean, when I check a
16 prescription, I look at that. I mean, I could
17 go over with you how I check a prescription, but
18 that -- I guess I just don't -- I guess I don't
19 understand why you're -- what you're asking.
20 There's nothing in the software.

21 Q. Okay. That's all I'm getting at.
22 There's nothing within the dispensing platform
23 or software that gives you that information,
24 right?

1 A. Right.

2 - - -

3 (Mooney Deposition Exhibit 1 marked.)

4 - - -

5 BY MR. GADDY:

6 Q. Okay. Okay. I am going -- we are
7 now going to kind of go through, I guess, kind
8 of the fill process. And there's a couple of
9 manuals that I found that I'm hoping are going
10 to help us with that.

11 So we're going to look at
12 P-HBC-1356, which should be tab number 6 in your
13 binder. And we'll mark this as Mooney Exhibit
14 Number 1.

15 And, Ms. Mooney, just let me know
16 when you've found that and you're with me.

17 A. I've found it.

18 Q. Okay. Now, we're going to look at
19 this one and one other. And I'll just represent
20 to you I didn't find a date on either of these
21 two documents, but I think this is going to be
22 the one that talks about the earlier system.

23 And as we go through it, we'll see
24 some screenshots from the PDX platform, which I

1 understand was the dispensing software that
2 Giant Eagle used for some point in time. And
3 then I believe you transitioned to another
4 dispensing platform. And so I think the second
5 manual will walk through that one.

6 Does that -- does that generally
7 make sense?

8 A. I'm not familiar with this, so I
9 don't --

10 Q. Okay. Do you think you've ever
11 seen this before? It says "Chapter One,
12 Introduction to Pharmacy" at the top.

13 A. No.

14 Q. Well, I don't -- I think it's
15 really just going to kind of be a guide for us
16 to help make sure we talk about all the
17 different areas of the Giant Eagle pharmacy.

18 So flip, if you would, please, to
19 the very next page where it says "Welcome and
20 Introduction" at the top.

21 Do you see that?

22 MR. MAZGAJ: Emily, have you
23 reviewed the document to your
24 satisfaction? Do you need some more

1 time?

2 THE WITNESS: Like I said, I
3 haven't seen this before, so -- it looks
4 like a technician handbook, so I
5 wouldn't have seen this.

6 BY MR. GADDY:

7 Q. Are you with me on the second
8 page, Ms. Mooney?

9 A. Yes, I am on the second page.

10 Q. Okay. Do you see at the top it
11 says, "Welcome and Introduction."

12 A. Yes.

13 Q. And it says, "Welcome. Thank you
14 for choosing Giant Eagle. This manual is
15 intended to help you learn your job and
16 responsibilities as a Giant Eagle pharmacy team
17 member."

18 Do you see that?

19 A. Yes.

20 Q. Okay. So what I want to do next
21 is just flip through the page -- or flip to the
22 next page, and you can see the next sectioned is
23 titled "Pharmacy Layout."

24 A. Okay.

1 Q. So can you kind of describe for me
2 in your own words -- and then we're going to
3 walk through -- and you can kind of flip the
4 page and see -- some of the different areas that
5 they're highlighting about the Giant Eagle
6 pharmacy. So we're going to cover some of these
7 in more detail.

8 But I kind of wanted to start with
9 just your own general description describing the
10 layout of your pharmacy in Painesville.

11 A. Okay. The -- our pharmacy does
12 not look like this one. Our -- we have
13 registers similar to that. There's two
14 registers at the front of the pharmacy. We have
15 a drive-thru probably 15 feet behind those front
16 registers as well with our will call bins of
17 prescriptions that are ready to be sold in
18 between there.

19 Our -- the drugs -- the shelving
20 with the drugs on it are through the middle of
21 the pharmacy. Our pharmacy counter is in front
22 of those. We have a drop-off prescription -- to
23 drop off prescriptions on the other side of the
24 pharmacy counter.

1 Our pharmacy itself is a little
2 longer than this one. I would say more of a
3 rectangle than the square that that one is.

4 Q. Okay. Let me ask you a couple
5 questions. So the drop-off area, you said you
6 have two registers at the drop-off area?

7 A. No. We have a separate drop-off
8 area. We have two registers for pick up.

9 Q. Gotcha. Okay. Are the registers
10 for pick up different -- different systems than
11 kind of the computers that you would have at the
12 drop-off area?

13 A. It's the same computer. We have
14 computers available at both. We just have
15 registers -- which is separate -- at those
16 computers and a designated area. And then for
17 drop off, we just have a scanner with the
18 computer to scan the prescriptions.

19 Q. Okay. And so at the drop-off
20 area, there's just one computer and one scanner?

21 A. Yes.

22 Q. Okay. And who works that drop-off
23 area?

24 A. Any -- anyone. Mostly

1 technicians. If we have the staff to work at a
2 drop-off, it just depends. We have a help tech
3 that kind of floats. Like I said, we don't have
4 a lot of drop offs as much anymore, so we open
5 that counter. But most of the time, those
6 patients will come through the drive-thru or to
7 the actual registers to drop off a prescription.
8 But anyone can take a drop-off script.

9 Q. So what happens when a script is
10 dropped off?

11 A. The technician will stamp the
12 prescription, name, date of birth, make sure the
13 patient is in the system. If they're not, we
14 add in their information, check and see if
15 there's any change to insurance.

16 Once we have all that information,
17 we'll scan the prescription into the computer,
18 and then the script will go to data entry to be
19 inputted into our system.

20 Q. Okay. Is that initial time at
21 intake, is that the only time that the
22 prescription is scanned into the computer?

23 A. Yes.

24 Q. Okay. What is scanned in?

1 A. It takes a copy of it. We put it
2 through a scanner, and the front and the back is
3 copied, photocopied, and then it goes right into
4 the -- as a digital image into our system.

5 Q. Okay. And so for a hard copy
6 script -- which I know you've told us is not as
7 common these days -- the process of receiving
8 the prescription, entering the -- you know,
9 stamping it, patient's date of birth and
10 allergies, entering data into the computer and
11 then scanning the prescription, all happens
12 right there at the drop-off counter?

13 A. Right.

14 Q. Okay. This is probably a silly
15 question, but is anything scanned if it's an
16 electronic prescription?

17 A. No. It is transmitted
18 electronically. So it will just automatically
19 show up in our data entry queue to be inputted
20 by the technician.

21 Q. Okay. For the drop off, is there
22 anything that changes about that process if
23 we're talking about a Schedule II or
24 Schedule III prescription? Is there any

1 requirement that a pharmacist does the drop-off
2 procedure and the data entry or any of those
3 types of things?

4 A. No. There is no -- there is no
5 difference in the dropping off of the
6 prescription other than -- I mean, this isn't a
7 standard or any sort of rule. It's just
8 something that I've implemented at our pharmacy,
9 is that if a technician gets a prescription for
10 a controlled substance, we immediately check and
11 see in their profile when the last time they've
12 had that prescription is.

13 A lot of times if we don't do
14 that -- the patient usually that goes to the
15 doctor and drops their prescription off right
16 away, it doesn't mean that it's ready to be
17 filled.

18 And at my location, we only fill
19 controlled substances a day early. So a lot of
20 times they will drop off their prescription
21 before that. So we -- and it's just our
22 practice to check and make sure when the last
23 time they filled it was so that we can tell the
24 patient before they leave if it's -- when it's

1 going to be ready. So if it isn't a day early,
2 then they have to wait. We reschedule that
3 prescription for the later date.

4 Q. Okay. But that's an Emily Mooney
5 rule, not a Giant Eagle rule?

6 A. Yes.

7 MR. MAZGAJ: Objection to form.

8 Q. Okay. You said you do have a
9 drive-thru at your store?

10 A. We do.

11 Q. Okay. Sorry. Before I go there,
12 so is there anything different about the
13 drop-off process if we're talking about a new
14 patient versus a repeat patient?

15 A. No, other than taking -- getting
16 their information and their insurance
17 information, address, phone. We have to put
18 them into the system. So that would be the
19 difference.

20 Q. Okay. Okay. So you said your
21 store does have a drive-thru, correct?

22 A. Yes.

23 Q. How is it determined as far as who
24 works the drive-thru? Is that a pharmacist

1 thing or a tech thing, or does it matter?

2 A. Typically a technician is
3 working -- that is where they're working, is at
4 the registers. They rotate between the two
5 depending on the time of day.

6 A pharmacist, though, can rotate
7 there. They go -- if they're the help
8 pharmacists, they would rotate to where they're
9 needed. So anyone, like I said, can work
10 dropoff, registers, drive-thru.

11 Q. Okay. Is the process for drop-off
12 at the drive-thru the same as the process for
13 drop-off at the counter as far as stamp it,
14 birth date, allergies, scan the prescription
15 front and back end, same as it was in the first
16 place?

17 A. Right. Yes, the same.

18 Q. Okay.

19 MR. MAZGAJ: We've been going
20 about another hour, Emily. How are you
21 doing?

22 THE WITNESS: Sorry. I could
23 probably be due for a break in the next
24 ten minutes or so.

1 MR. GADDY: It's up to you. We'll
2 be on this document for longer than
3 that, so -- but whenever you want to
4 take a break.

5 THE WITNESS: Okay. We can go to,
6 like, 12:15 then.

7 MR. GADDY: Okay.

8 BY MR. GADDY:

9 Q. All right. If you turn the page,
10 there is -- I'm on page -- there's page 4 down
11 at the bottom. It talks about the will call
12 area. What's that?

13 MR. MAZGAJ: Hey, Jeff. Will you
14 give me a continuing objection just on
15 this document with lack of foundation?

16 MR. GADDY: Sure.

17 MR. MAZGAJ: Thanks.

18 A. Will call is where the
19 prescriptions are stored and then picked up
20 from.

21 Q. Okay. And you have that area at
22 your store in Painesville?

23 A. Right. Right by the registers.
24 The bins are similar. The two registers in the

1 front, the will call bins, and then the
2 drive-thru behind it.

3 Q. Okay. So who would work the will
4 call area?

5 A. Like I said, anyone can work those
6 areas. Typically a technician would be at the
7 registers, which encompasses that register and
8 drive-thru.

9 Q. Okay. The next -- the next
10 section on this page says "Data Entry." Is that
11 what we've already kind of covered as far as
12 what happens at drop-off, or is this something
13 different?

14 A. No. Data entry is the process of
15 entering the prescription, the data from the
16 prescription, into our computer system.

17 Q. Okay. Where does -- does that
18 happen at drop-off, or does that happen
19 somewhere else?

20 A. It can happen at drop-off, but
21 usually that happens on our main line. Ours is
22 structured where the pharmacist is in the middle
23 of the counter, and then we have two technicians
24 on either side with some distance between.

1 We have a fill station where the
2 technician typically fills prescriptions. And
3 then the other side is usually just for data
4 entry. They usually have filled or data entry
5 on both of those computers, depending on the
6 time of day. But for the most part, we have one
7 spot where they do most of the data entry.

8 Q. Okay. Who does the data entry?
9 Is that a tech thing, a pharmacist thing, or
10 either/or?

11 A. Both. Typically it's a
12 technician. Usually it's my strongest
13 technicians. I have two advanced technicians at
14 my store where they've -- there's a series of
15 tests for technicians, and they've passed all of
16 those tests. It's a full-time position. I give
17 them a little more responsibility when it comes
18 to ordering supplies and helping me input
19 scheduling and things like that.

20 They are typically my data entry
21 technicians, but that is something that all of
22 the technicians learn to do, and they all rotate
23 through these stations.

24 Q. Okay. What information is entered

1 from a prescription? And if you don't mind,
2 just kind of answer generally and then give me
3 an example of what would be entered from a
4 typical oxycodone prescription.

5 A. Okay. So they would see the
6 prescription on the screen. When we're data
7 entering a prescription, we select the patient's
8 name. That's why we get their information at
9 drop-off in case they're not in our system. We
10 get their name by searching by their date of
11 birth. Next to that is the date that the
12 prescription is written. We input that date.
13 Then we search for the drug.

14 So in our system, it's easier to
15 search oxycodone. We usually just type the
16 first three or four letters of the drug along
17 with the strength, so 5 milligrams, oxycodone
18 5 milligrams.

19 We find that. Select it. Move to
20 the next, which would be quantity. We'd input
21 the quantity. Then the directions. They'd type
22 out the directions. After that is the doctor.

23 So they would -- in the fact of a
24 controlled prescriptions, they would search by

1 the DEA. My technicians are trained to know
2 what to look for on the prescriptions.

3 So in this case, if the DEA is not
4 there, we would immediately put that into our
5 call queue to call the doctor to get that
6 information because it needs to be on the
7 prescription.

8 So on a controlled medication, we
9 would search by the DEA, pull up the doctor,
10 select it. And then after that is the day
11 supply. It's required on a controlled
12 medication to write the duration of therapy on
13 the prescription. So we make sure that is on
14 there.

15 And then the refills, if there is
16 a refill, obviously OxyContin or oxycodone, you
17 can't put a refill on that, so it would be zero.
18 At that point, you'd check insurance.

19 The next screen will prompt you to
20 put in a diagnosis code, because that is
21 required on a controlled prescription. So you'd
22 put in the diagnosis code. If it's not there,
23 again, it would go right into the call queue for
24 a pharmacist to call and clarify the diagnosis.

1 After that, you might -- another
2 screen might pop up to show the actual product
3 that we have in stock, to select that. And then
4 it would be put through -- you'd put your
5 biometrics down -- or into the computer to send
6 it off to the pharmacist to do data
7 verification.

8 Q. Okay. When you said DEA, were you
9 referring to a DEA registration number for a
10 doctor?

11 A. Yes, yes. Every doctor has their
12 own DEA number, and it is required to be on the
13 prescription.

14 Q. Okay. And when you said
15 biometrics there at the end, I don't know what
16 you meant by that.

17 A. Sorry. Our credentials. Every --
18 everyone that works in the pharmacy uses their
19 fingerprint to stamp what each person has done
20 so we can track what is being done based on who
21 is doing that in the system.

22 And in order to get to the next
23 screen, you have to put your biometrics in
24 showing that you typed that prescription or you

1 data entered that prescription.

2 Q. Okay. And so that's the data
3 entry process in a nutshell, right?

4 A. Right.

5 Q. Okay. And I think you said the
6 next step from there would be data verification?

7 A. Correct, as long as it doesn't go
8 to third-party rejection. A lot of
9 prescriptions, they'll immediately get billed to
10 the third party, their insurance company. And
11 if they get rejected by the insurance, they
12 would go to that queue first. But for the most
13 part, they get billed to insurance and then go
14 right to data verification.

15 Q. Okay. And what is data
16 verification?

17 A. That is what the pharmacist does
18 to verify the prescription.

19 Q. Okay. And is a pharmacist in
20 charge of data verification for every type of
21 prescription, or is that just a controlled drug
22 thing?

23 A. Oh, every prescription that is put
24 into the system goes to data verification, every

1 one.

2 Q. Okay. So tell me generally what
3 happens as it relates to data verification. And
4 then if you would, also tell me specifically
5 what happened -- well, let's just start in
6 general.

7 Tell me generally what happens at
8 data verification, and then I'm going to ask you
9 some more questions about controlled substances
10 after that.

11 A. Okay. Well, I mean, I can use
12 oxycodone as an example.

13 So data verification, it's
14 similar. I put my biometrics in. A
15 prescription will pop up on my screen. I have a
16 picture of the hard copy prescription on the
17 right-hand side of the screen, and then what my
18 technician inputted into the system on the
19 left-hand side.

20 The computer system that we have
21 now, it's pretty nice. It goes line by line.
22 So I can hit enter to check each line. So
23 similar to data entry, it is the same. I'm
24 checking the name and date of birth.

1 So when I am checking the name,
2 I'm making sure that the name is correct, the
3 date of birth matches. I also -- in my head,
4 I'm looking for, you know, age. Is this a
5 pediatric patient, an elderly patient?

6 Next I would check the drug, make
7 sure that the drug is what is on the
8 prescription. So I check the drug, the
9 strength, and the form, whatever that may be, a
10 tablet, a capsule, extended release suspension,
11 make sure that those match up.

12 After that, I check the quantity,
13 the refills, the doctor. With the doctor and an
14 oxycodone prescription, I make sure that that
15 DEA is there. I make sure -- MPI helps too, but
16 I need to have the DEA there. That the
17 prescription is signed. That happens a lot
18 where it's not signed.

19 And in the respect of a C-II
20 prescription or a controlled prescription, if
21 it's not signed, then that script is not valid.
22 If it's a hard copy, it would have to go back to
23 the doctor's office to be signed or rewritten.

24 After I talk to the doctor, I go

1 back through the prescription and make sure the
2 prescription makes sense, that the dosing is
3 appropriate for that drug. And then I'll move
4 on.

5 My next screen -- after doing the
6 check of just the prescription, my next screen
7 would be my DUR screen, allergies. Those would
8 be listed there.

9 We have -- so if there's -- on a
10 DUR screen, allergies can be one of them. If
11 the patient has any other medications that are
12 similar to it in the same class that they've
13 recently gotten, I look through that.

14 In this old system, we wouldn't
15 have a DUR screen. It was a little bit
16 different. They kind of printed after the fact.
17 So in that case, I would check their profile.
18 And a lot of times, I still check the profile
19 depending on what the DURs are telling me.

20 A lot of times patients are -- the
21 oxycodone example, they might have got
22 5 milligrams last time, this one is for
23 10 milligrams. So I'm going to put a counsel
24 note in to discuss that with the patient, that

1 there was a change in therapy.

2 At this point, I'd also check to
3 see if the patient's filled that before, why the
4 jump. And you can see if they've filled it in
5 previous times, if they're filling it too early.

6 A lot of times even with a jump
7 from 5 to 10 milligrams, I would do a
8 calculation; "Okay. So should they have enough
9 filled for getting this prescription at 10
10 milligrams, should they have enough of doubling
11 up on their 5s to get them to a certain date
12 before I fill this?" These are some of the
13 things going through my head.

14 For an oxycodone prescription, an
15 OARRS tab will show up in my computer system,
16 and I have to click on that, or override it.
17 And I never override it.

18 I'd click on that and check the
19 OARRS report also on this screen, make sure they
20 haven't filled at any other pharmacies, any
21 other doctors.

22 Sometimes dentists, in particular,
23 will write for prescriptions that -- for tooth
24 pain and an immediate need, but they don't --

1 they don't typically check OARRS like I would.

2 So.

3 I will see that, you know, they
4 got an oxycodone prescription just the other day
5 from a pain management doctor and now they're
6 getting this. So that would flag me to check
7 and call them -- call the doctor.

8 After the OARRS, as long as
9 everything checks out okay, I can continue. The
10 next screen sometimes is billing, but for the
11 most part, that's the last screen I would look
12 at. It just shows the -- what it's been billed
13 to. And then I would put it in my biometrics to
14 approve it as well, or reject it to the call
15 queue depending on what the script is or if
16 there's any issues.

17 If there was any change in dose, I
18 would deactivate an old prescription and then
19 put a counsel note, so then I would make sure to
20 speak with the patient and make sure they're
21 aware of a dose change.

22 Any questions I had, I would also
23 put in a counsel note. If there was a question
24 about an allergy or something like that, I would

1 do that at that screen as well.

2 I think that covers most of the --
3 just some of the process with data verification.

4 Q. Okay. Let me ask you a couple
5 follow-up questions about that while it's still
6 fresh in your mind, and then we can take a
7 break, if that's okay.

8 That whole process that you just
9 described, the data verification, about how long
10 does that take you?

11 A. It depends on the prescription
12 obviously. I mean, there's a lot of what-ifs, a
13 lot of things. It depends on what I see. So, I
14 mean, a controlled prescription typically takes
15 longer because I will check that OARRS. There's
16 more information that needs to be on the
17 prescription than on a standard legend drug.

18 I mean, I would say for a normal
19 maintenance med prescription, I'd say a minute
20 or so, maybe more, depending if there's any
21 interactions, because I can check -- we have
22 tools, if there's an interaction that I can
23 check and make sure that the interaction is
24 something I can counsel them more on or if it's

1 something I need to call the doctor on and
2 change the drug completely.

3 So I would say on average, about a
4 minute. I would say controlled medications,
5 typically longer just because of the OARRS
6 report and the more detail that is required
7 there. Probably double the time, I would say.

8 Q. Okay. So as far as how long it
9 takes for you to do the data verification
10 process, you said for a normal non-controlled
11 medication, approximately a minute. But when
12 we're dealing with a controlled substance, such
13 as an opiate, approximately two minutes to do
14 the data verification process.

15 Is that fair?

16 A. Yes, as long as there's no issues.
17 Yes.

18 Q. Okay. One of the things that I
19 heard you say in your answer that you would look
20 at during the data verification process would be
21 the dosing and the length of treatment, and I
22 think you said you would look at those types of
23 things to see whether or not they made sense.

24 Do you recall that generally?

1 A. Yes.

2 Q. Okay. And you agree that those
3 are the types of things that fall within your
4 job responsibilities as far as performing due
5 diligence in carrying out your corresponding
6 obligation regarding whether or not a
7 prescription, particularly for a drug like an
8 opiate, should be filled?

9 MR. MAZGAJ: Objection to form.

10 A. I -- it is my corresponding
11 responsibility to do that for every
12 prescription, no matter what. So that is in my
13 process for every prescription. I need to know
14 that it makes sense the way that it is written.

15 Q. You mentioned a couple of times --
16 you used the term "counseling note." I'm making
17 an assumption that that means talk to the
18 patient when they come to pick up their
19 prescription; is that right?

20 A. Right.

21 Q. Okay. Are there any -- and you've
22 told me about a couple of instances where you do
23 things maybe a little over and above that maybe
24 aren't necessarily required by the company, but

1 you like to do them.

2 So I want to understand if there's
3 any Giant Eagle policies, rules, or regulations,
4 and then if there's any, you know, Emily Mooney
5 policies, procedures, or regulations regarding
6 counseling as it relates to opioid drugs.

7 So why don't you kind of first
8 tell me your particular way to do things and
9 then whether or not you do those because you
10 think they're the right thing to do or you do
11 them because there's a Giant Eagle policy that
12 tells you you have to.

13 Does that make sense?

14 A. Right.

15 Q. And I'm specifically asking about
16 counseling as it relates to opioid drugs.

17 A. Okay.

18 MR. MAZGAJ: Objection to form.

19 A. There is a standard from Giant
20 Eagle in place for counseling, and I don't think
21 it's an Emily Mooney thing so much as a company
22 thing.

23 I -- Giant Eagle is very dedicated
24 to the safety of the customers. I think as a

1 company, they go over and above to where, for
2 example, changing in dose for counseling
3 purposes, I flag that in our computer system to
4 counsel every time.

5 And typically -- I mean, even
6 before this system -- it would be a note on the
7 bag to -- it's not technically counseling even
8 just to state that this is a different dosage
9 than what they have gotten before.

10 So really that's -- it's not so
11 much a counsel. Sometimes it leads to
12 counseling because they do have questions. And
13 then in that case, you'd ask the pharmacist.
14 But the Giant Eagle's system has so many
15 safeguards.

16 I mean, just putting in change in
17 dose, that automatically brings a pharmacist to
18 the counter to talk to the patient when
19 typically -- and it maybe it's not something
20 that a pharmacist needs to technically state to
21 the patient. I don't know if that makes sense.

22 But they do go kind of over and
23 above. The system has so many safeguards that
24 something as simple as just stating that this is

1 a change in dose than last time, which a
2 technician could essentially tell them that, is
3 now put into our system that the pharmacist will
4 address it. So I like --

5 Q. I'm sorry. I didn't mean to cut
6 you off.

7 I'm guess I'm trying to
8 understand. Is there a Giant Eagle policy that
9 directs that any time there's a change in dose
10 for medication, counseling is required?

11 A. No. More so that -- like, if
12 there is a change like that, you have to offer
13 the right to counsel. I'm just using it as an
14 example, that technically, I mean, we can tell
15 the patient that, but our system is built so
16 that we're automatically going to the counter to
17 ask them if they have -- or follow up and ask
18 questions right away.

19 Q. Is there any policy within Giant
20 Eagle that every patient who fills an opiate
21 script should receive counseling?

22 A. Well, it's Ohio law to offer
23 counseling at every transaction. So it's all
24 encompassing. Which we do. Our technicians at

1 will call will ask if we -- if the patient
2 requires counseling or if they have any
3 questions. So we offer counseling to every
4 patient.

5 Q. Okay. My question is a little bit
6 different.

7 Is there any requirement from
8 Giant Eagle that you must counsel the patient,
9 whether the patient wants it or not, that you're
10 not letting that script out the door until you
11 talk to that patient about an opioid
12 prescription?

13 Is there any policy like that in
14 place at Giant Eagle?

15 MR. MAZGAJ: Objection to form.

16 A. Like I said, we have to offer to
17 counsel for every prescription. It's not
18 required to counsel on an opioid prescription
19 unless there is -- or if the pharmacist feels
20 there's a need to require counseling on that
21 prescription, whatever it may be.

22 As a change in dose, yes, I would
23 make sure that we're counseling on something
24 like that. If there is a duplication with

1 another drug that they were on prior, I will
2 definitely counsel and make sure that that
3 patient knows that they can't take both
4 medications, or one or the other, things like
5 that.

6 But there's no requirement with
7 Giant Eagle, per se, because the state requires
8 us to do that. So Giant Eagle will require that
9 based on the state laws.

10 Q. Okay. When you say --

11 MR. MAZGAJ: Hey, Jeff. It's

12 12:30.

13 MR. GADDY: Yeah. I'm close,

14 Matt. Just a couple more.

15 MR. MAZGAJ: Okay.

16 BY MR. GADDY:

17 Q. When you say "offer to counsel,"
18 does that mean that when they're handed the
19 prescription, the customer is asked whether or
20 not they'd like to speak with the pharmacist
21 about their prescription?

22 A. Yes. Before -- as we're putting
23 the prescription -- checking the patient out in
24 will call at the register, they have to sign off

1 on the right to counsel if they refuse or they
2 accept.

3 Obviously if they have a question,
4 we require it, and we'll make sure that we do
5 the counseling. But if it's a normal
6 prescription or any prescription that there's no
7 questions from the pharmacist, we still have to
8 offer counseling.

9 Q. Okay. And the patient has the
10 ability to say, "No thanks, I'm good" and just
11 take their prescription and leave?

12 A. Right.

13 MR. MAZGAJ: Objection to form.

14 MR. GADDY: Okay. We can go ahead
15 and take a break now. How long do you
16 want -- I'm sorry. Go ahead and go off
17 the record.

18 THE VIDEOGRAPHER: Off the record,
19 12:32 p.m.

20 - - -

21 Thereupon, at 12:32 p.m. a luncheon
22 recess was taken until 12:56 p.m.

23 - - -

24

1 Friday Afternoon Session
April 16, 2021
2 12:56 p.m.

3 - - -

4 THE VIDEOGRAPHER: On the record,
5 12:56 p.m.

6 BY MR. GADDY:

7 Q. Ms. Mooney, this process of data
8 verification that you described to us before we
9 broke for lunch, is that generally the process
10 or the time period in which you're doing what I
11 think you called your due diligence in trying to
12 make a determination about whether or not a
13 prescription for a drug like opiates should or
14 should not be filled?

15 A. Yes. During the DVP process would
16 be when I would be doing that.

17 Q. Okay. And are there ever
18 occasions throughout your career as a Giant
19 Eagle pharmacist that you have made a decision
20 not to fill a prescription for an opiate?

21 A. Absolutely.

22 Q. Can you tell me -- I'm trying to
23 find out how often that's occurred. So can you
24 tell me an approximate number of times you've

1 refused to fill an opiate prescription, or if
2 it's easier to tell me number of times per week
3 or per month, knowing that it would be an
4 approximation. I'm trying to get a number from
5 you.

6 MR. MAZGAJ: Objection to form.

7 A. I -- like, I can't give you a
8 number per se, and it depends on what you are
9 constituting "not filling." A lot of the
10 time -- I mean, I don't fill prescriptions
11 multiple times a day, especially when it comes
12 to filling a patient's prescription too soon.
13 I -- like I said, I will only fill a
14 prescription a day early that is for a
15 controlled medication.

16 So there's many, many times a day
17 that I am rescheduling those prescriptions for
18 when they are due instead of filling them.

19 Q. Okay. Well, that's helpful. So
20 let's put those into one category.

21 And you said -- and I can't
22 remember if this is an Emily Mooney policy or if
23 this is a Giant Eagle policy. But you told us
24 earlier that you would only fill controlled

1 prescriptions, I think, one day before they
2 would be -- before they would be up; is that
3 right?

4 A. Right.

5 Q. Okay. Is that a Giant Eagle
6 policy, or is that your personal policy?

7 A. No. That's just doing my due
8 diligence. They don't put that stipulation on
9 my practice.

10 Q. Okay. So that's a decision that
11 you make to make sure that you are doing things
12 as appropriately as possible?

13 A. Right, and I'm supported by the
14 company. Yes.

15 Q. Okay. Okay. So setting aside
16 prescriptions that you maybe get two or three or
17 four or more days early and that you say, "Okay.
18 Well, I'll look at these closer to time." But
19 what I want to know is whether or not there are
20 any prescriptions for opiates that you have been
21 presented with during the course of your career
22 as a Giant Eagle pharmacist that you made a
23 determination that, "No, this prescription
24 should not be filled based on a reason other

1 than it being a day or two early."

2 Does that make sense?

3 A. Yes. And that happens quite
4 frequently too. An example like I gave earlier
5 with a dentist's office in particular or ER
6 prescriptions, those doctors don't typically see
7 the patient as much, and they don't always check
8 an OARRS report before giving them a narcotic or
9 an opiate.

10 And in that case, I make sure that
11 the doctor that wrote that new prescription for
12 the breakthrough pain or whatever it is, that
13 they are already on a long-term opiate or that
14 they've had that recently.

15 And in that case, after that
16 discussion, the doctor usually chooses not to
17 fill the prescription, and then we don't fill
18 it.

19 So that happens quite frequently
20 too.

21 Q. Okay. Outside of dentists and
22 emergency room doctors, are there any other
23 types of physicians that you often have issues
24 with them not checking OARRS or not being as

1 familiar with the history of the patient?

2 MR. MAZGAJ: Objection to form.

3 A. Yes. I mean, over the years,
4 those have gone down. Like I said earlier, most
5 doctors, most physicians now will put checking
6 OARRS into their practice. So I don't have as
7 many of those as I used to, but it has happened,
8 and in the past especially.

9 Q. And was that, you know, also a
10 problem prior to OARRS being up and running
11 where you would have issues where doctors may
12 not be as familiar with the history of their
13 patient and cause you to maybe have to do a
14 little bit more due diligence as the pharmacist?

15 A. Yes. There is a huge difference
16 in my -- the way I practice then to now. I used
17 to be on the phone a lot with doctors' offices,
18 with pharmacies, trying to figure out if -- you
19 know, if it was a new patient that I wasn't
20 familiar with, things like that, I would have to
21 do a little bit more digging. And I did all the
22 time, so ...

23 Q. Okay. So if you had to tell me
24 over the past -- let's just say over the past

1 month, do you believe that you've refused to
2 fill any opiate prescriptions over the past
3 month not for the early refill issue, but
4 because you determined that the prescription
5 shouldn't be filled?

6 A. Yes.

7 MR. MAZGAJ: Objection to form.

8 Q. Approximately how many times over
9 the past month do you think you've done that?

10 MR. MAZGAJ: Objection to form.

11 A. I don't know. Probably -- I mean,
12 at least once a week I would say I end up with
13 something like that, something similar to that
14 situation.

15 Q. Okay. And when you -- when you
16 tell me -- again, and this is totally
17 approximate. I'm not holding you specifically
18 to this number. But when you tell me "about
19 once a week," are you talking about for your
20 whole pharmacy or just for you?

21 A. Me, or at least being there when
22 something like that happened. Maybe not me in
23 particular, but one of the pharmacists I'm
24 working with that day.

1 Q. Okay. And is that approximately
2 once a week as far as refusing to fill an opiate
3 prescription, not because it's been presented by
4 a patient a few days too early but because
5 you've otherwise determined it shouldn't be
6 filled, is that fairly consistent going back in
7 time, that once a week?

8 A. Like I said, it was more back when
9 OARRS was not readily available or the
10 physicians did not use it as much I did, so ...

11 Q. Okay. So pre-2013ish, it would
12 have been more than once a week, and 2013ish
13 forward, approximately once a week; is that
14 fair?

15 MR. MAZGAJ: Objection to form.

16 A. No. Even moving past 2013. I
17 mean, I know I was using OARRS as soon as it
18 became available. I don't know if physicians
19 were. And so I found a lot of things on there
20 that I don't think that the physicians were
21 aware of, so ...

22 Q. Okay. So safe to say that it was
23 more than once a week, and as OARRS became
24 available and maybe as people became familiar

1 with it, that slowly got down to where it
2 averaged out about once a week to where it is
3 now?

4 A. Right.

5 MR. MAZGAJ: Objection to form.

6 Q. Okay. I would presume that from
7 time to time during the course of your due
8 diligence process during the data verification
9 step, that there's -- you've had occasions -- I
10 think you've already said this -- to call
11 doctors and ask them about the circumstances in
12 which they've written an opiate prescription?

13 A. Yes.

14 Q. Okay. Can you kind of just give
15 me an example of how that conversation goes as
16 far as who you -- who makes the call, whether
17 it's you or a tech, who you speak with at the
18 physician's office, if there's a standard, or if
19 it changes from time to time.

20 A. Typically if I have an issue with
21 a prescription, I call myself, especially
22 regarding opiate prescriptions and controlled
23 medications. I usually talk to a secretary or a
24 medical assistant or a nurse. It just -- it

1 depends on the office. And I usually have to
2 leave a message with them. They talk to the
3 doctor, and then they get back to me. It just
4 depends on the office.

5 Q. Okay. And what types of questions
6 are you usually asking to the secretary or the
7 physician's assistant or the nurse?

8 A. I mean, it depends on the
9 prescription and what my -- let's see.

10 So one example of something more
11 recent within the last year or so is -- and it's
12 not -- is patients that will call in
13 prescriptions posing as an office where they'll
14 call in a prescription and they know the
15 doctor's DEA. They know the necessary
16 information that the pharmacy would need to call
17 in a prescription for a medication that's
18 controlled.

19 And so now typically, too, any
20 medications that are controlled and called in
21 and left on my voicemail, I will typically call
22 the doctor's office using our own pharmacy
23 number that we have on the doctor's file and not
24 the number that's written -- or that we've

1 recorded from our messages.

2 So I verify -- I call that office,
3 "Hey, this patient, I just got a prescription on
4 my voicemail for this. I just want to clarify
5 that this prescription did indeed come from this
6 office." And I can find out that way if the
7 prescription is legitimate to fill. I've caught
8 a few prescriptions, fake prescriptions, called
9 in that way. So that's one way I can call and
10 verify.

11 Q. Okay. Have there ever been
12 occasions where you've called doctors' offices
13 with questions regarding the dosage that was
14 written? Let me just leave it at that.

15 A. Yes. Yes. I have called on
16 medications in the past. If they're high doses
17 or -- but that's not as typical. It more -- day
18 supply is another one that I will call on. Some
19 patients are on a 90-day supply of long-acting
20 pain medication.

21 In this case, I usually -- if I
22 don't -- if I haven't seen the patient before --
23 and, you know, prior to OARRS and even after, if
24 I see that they've jumped from a 30-day to a

1 90-day prescription, I call, and I ask them why
2 they're doing this.

3 And usually I get some information
4 from their chart to document the necessity to
5 fill 90 days' worth of a prescription opiate.
6 I've done that before.

7 So any change that's not a
8 normal -- and as I'm checking, I don't -- and I
9 see as an issue, I will call on.

10 Q. And for those issues where you
11 would call regarding dosage or change in therapy
12 and those types of things, are you also calling
13 and speaking with the secretary or the assistant
14 or the nurse and leaving a message for the
15 doctor to have those questions answered?

16 A. Yes. I usually leave a message.

17 Q. Okay. How often do you actually
18 talk to the doctor?

19 A. That depends, but it is more
20 infrequent. Usually I'm speaking with the
21 nurse. The only time I end up usually talking
22 to the physicians are on weekends. If I have a
23 pertinent question and will not fill a -- you
24 know, a controlled medication on the weekend,

1 usually it's the doctor on call. So I speak
2 with the doctors more on weekends than I do
3 during the week.

4 Q. During the week, it's typically
5 secretary, assistant, nurse, correct?

6 A. Right.

7 Q. Okay. Has there ever been an
8 occasion that you can remember that you called a
9 physician's office regarding an opiate
10 prescription and they gave -- they told you that
11 it was okay to fill the prescription, but you
12 still decided that you weren't comfortable
13 filling it and you still refused to fill the
14 prescription?

15 A. I -- not -- I don't recall
16 anything that can come to mind. I don't know.

17 Q. Okay. Is there any way or any
18 requirement within Giant Eagle that you document
19 the fact that you've refused to fill a
20 prescription for an opiate?

21 A. Yes.

22 MR. MAZGAJ: Objection to form.

23 A. I can document -- any time I
24 deactivate a prescription in someone's profile,

1 you have to put in a note as to what happened or
2 why, and then we have to put our initials -- so
3 while it's more of a note standard so that we
4 know who wrote that note, who did the -- who
5 deactivated the prescription. So, yes, there is
6 notes in our system for that.

7 Q. Okay. So if a prescription for
8 oxycodone comes in, as we already kind of
9 covered, the first thing that's going to happen
10 is that -- or one of the first things that is
11 going to happen is that prescription is going to
12 be entered, right, so it's in the Giant Eagle
13 system, correct?

14 A. Right.

15 Q. Okay. And then if you are doing
16 your data verification process and for whatever
17 reason you determine that you're not going to
18 fill the prescription within the system, you
19 have to deactivate the prescription; is that
20 right?

21 A. Yes. Yes. It's called
22 deactivating in our system.

23 Q. Okay. And when you deactivate a
24 prescription, is there a requirement that you

1 make a note?

2 A. Yes.

3 Q. Does the software force you to
4 make a note before you move on?

5 A. Yes.

6 Q. Okay. And is there -- what would
7 you call -- and I think we'll cover this in a
8 little bit, but I know there's different areas
9 within the software where you can make notes.

10 Is there a -- what title would you
11 give to this notes area where you are being
12 forced to enter? Is this a deauthorization note
13 or a patient note?

14 A. Reason for deactivation. It's
15 just giving a reason to deactivate.

16 Q. Okay. And I think I heard you say
17 that you'd put your initials in there and then
18 you would make a note?

19 A. Right. Giant Eagle has a notes
20 standard, and so you would put in either a "P"
21 or a "T" for pharmacist or technician. The
22 first letter would be your first name, your full
23 last name, and then the date. So any time you
24 put a note in the system, that is what you're

1 using.

2 Q. Okay. And I assume this is like a
3 free flow text box? It's not like there's a
4 drop-down menu of reasons to pick, right?

5 A. Right.

6 Q. Okay. Can you give me an example
7 of what you might put in that text box if you
8 made a determination that there's not a
9 legitimate reason for an opiate script and so
10 you're not going to fill it?

11 A. Well, just, for example, the
12 calling a dentist's office, I would put spoke
13 with -- "Spoke with so and so at dental office,
14 doctor decided not to fill," and I would put in
15 my credentials and deactivate the prescription.

16 Q. Okay. Is there any other
17 information that goes into that deactivation
18 notes field other than the reason that you're
19 not filling the prescription?

20 A. No.

21 Q. It's not like a general notes
22 field where you could put, you know, different
23 information about other things? It's specific
24 to that one issue of deactivating the

1 prescription?

2 A. Right. We have a notes tab to put
3 other notes, if necessary, for other medications
4 or for the patient.

5 Q. Okay. As it relates to the data
6 verification process, let me ask you some
7 questions about some of the other areas that you
8 might either make or look at notes.

9 So what notes do you have
10 available to you that may have been entered by
11 other pharmacists or other technicians while
12 you're going through the data verification
13 process?

14 MR. MAZGAJ: Objection to form.

15 A. As -- in data verification on the
16 screen of -- on the DUR screen where I see
17 interactions and where the OARRS is available,
18 there's also a notes field. It's in the bottom
19 left-hand corner of the screen that shows all
20 the notes that are in the patient's file.

21 So, I mean, typical notes -- this
22 just comes to mind -- is like if I'm checking a
23 prescription, sometimes people are on two
24 strengths of a medication, a thyroid medication,

1 and that will flag in our DUR screen that it's a
2 duplicate -- it's a duplicate drug, and we have
3 a note or we'll put a note in that we know that
4 this patient has been on two strengths. So
5 things like that. To help us in the checking
6 process, those are available on that DUR screen.

7 Q. Okay. Is there a title for that
8 notes field? Is that DUR notes? Is that
9 patient notes. Or do you know?

10 A. There is -- you can have notes --
11 there's a notes tab, and you can have notes
12 appear at different -- you can make a general
13 note to have them appear at every step
14 throughout the fill process, or you can make
15 them show up for, you know, certain -- at
16 certain times.

17 If it's a note on the patient that
18 we need at will call, we can select that it's
19 just for will call when we ring out a patient.
20 But in the DUR screen, it shows the general
21 patient notes.

22 Q. Okay. And the type of information
23 that's going to be in the general patient notes
24 would be one of the examples that you just gave

1 like on different multiple medications of
2 different strengths for maybe a thyroid
3 condition?

4 A. Right. It can be --

5 MR. MAZGAJ: Objection to form.

6 Q. You can go ahead.

7 A. Yes. It can be for any of those
8 sort of things, any note that we would want to
9 make on a patient.

10 Q. Okay. Are there any other notes
11 areas? We've got the deactivation note. We've
12 got the general notes that you say are going to
13 display during the DUR process.

14 Any other areas that you can make
15 notes that you would have available to look at
16 during that data verification process?

17 A. We make -- we do make notes on the
18 image. So like if we spoke with the doctor's
19 office regarding anything about the
20 prescription, an allergy that we wanted to
21 clarify, a clarification on the directions, if
22 something is illegible, any reason why we would
23 call the doctor, we document that on our image
24 note. So that is attached to the prescription.

1 Q. Help me understand that. That's a
2 note -- is that a note field, or is that where
3 you're making entries on top of the prescription
4 that's been scanned in or --

5 A. Let me -- so with our previous
6 system, before we were able to scan hard copies
7 into the computer system, any time we had a
8 question on a prescription, any time we spoke
9 with a doctor's office, with a pharmacy, we
10 didn't -- you know, those note fields in our old
11 system weren't there. All of our documentation
12 was done on the prescription itself. So we
13 would make notes all over those prescriptions.

14 Our computer system now still
15 makes -- let's us make those notes, but it's in
16 a field that if we printed the prescription from
17 our computer system, the notes would be bulleted
18 at the bottom of it.

19 So we still do those same notes.
20 They're just attached to the prescription in a
21 file, like, instead of written on the
22 prescription itself.

23 Q. Okay. At what point in time did
24 the system change to where you were able to scan

1 and upload hard copy prescriptions?

2 A. Somewhere around 2013, '14 maybe
3 is when we got the new prescription system, the
4 new -- our new pharmacy system.

5 Q. From some of the other depositions
6 that have happened, I have a general
7 understanding that there was a period of time in
8 which the system that you used was a PDX system,
9 and you also had an rx.com system that kind of
10 also ran in the background.

11 Do you know what I'm referring to
12 there?

13 A. Yes. We use a PDX system. I
14 remember rx.com, but I don't really know what
15 that is.

16 Q. Okay. Do you still use Rx.com
17 now?

18 A. No. I don't know -- I don't know
19 really what that is.

20 Q. Okay. If you pull up a patient
21 today who comes into your store, are you able to
22 see their history across -- let me give you a
23 couple of options.

24 Can you see their history within

1 your particular Giant Eagle store? Can you see
2 it within all Giant Eagle stores? Or can you
3 see it within all other chains as well outside
4 of Giant Eagle?

5 MR. MAZGAJ: Objection. Objection
6 to form.

7 A. We -- we can see all prescriptions
8 filled at Giant Eagle.

9 Q. Okay. And how long has that been
10 the case?

11 A. I'm not sure of a time period.
12 Quite a few years now. I don't know how long.

13 Q. Okay. So if you were to look at a
14 patient who has had a prescription filled at a
15 separate Giant Eagle pharmacy, are you able to
16 see hard copy prescriptions that have been
17 scanned in at that other Giant Eagle pharmacy?

18 A. Yes. We can see the original
19 prescription from the other pharmacy. Yes.

20 Q. Okay. If you look at that
21 prescription that was filled at another Giant
22 Eagle pharmacy, are you able to see the bullet
23 point notes that you said would be displayed
24 below the prescription for scripts in your own

1 store?

2 MR. MAZGAJ: Objection to the line
3 of questioning as duplicative of
4 30(b)(6) testimony.

5 You may answer.

6 A. Yes. We can see the notes
7 underneath that the other pharmacy has written.

8 Q. Okay. The deactivation notes that
9 you talked about, are you able to see those
10 across the chain?

11 A. I -- we can see that something has
12 been deactivated. Yes, because we can click on
13 the deactivation -- yes, you can see the notes.

14 Q. Okay. So if a patient came in and
15 presented you with a hard copy prescription for
16 oxycodone, you would have the ability to get
17 onto your system, see that they'd been at the
18 Giant Eagle a couple miles away the day before,
19 and that a prescription for oxycodone had been
20 deactivated? You would have the ability to see
21 that?

22 A. Yes, we could see that.

23 Q. Okay.

24 A. Through that way and from the

1 prescription, so ...

2 Q. Okay. And do you have the ability
3 to see which particular pharmacist refused or
4 deactivated the prescription the day before and
5 any notes that they made?

6 A. We can definitely see the notes.
7 I'm not sure on the pharmacist. I'm not sure
8 about that.

9 Q. I was just referring to -- you
10 said it was standard to insert first initial,
11 last name, those types of things. Is that going
12 to be included in the note?

13 A. That I could see, like, on the
14 notes. Yes. So if the note is there, we can
15 see the note.

16 Q. Okay. Let's go back to this
17 Exhibit Number 1 that we were looking at before
18 the lunch break. I'm just going to ask you
19 about a couple other areas.

20 If you look at page 6 of that
21 document, there's a section at the top that says
22 "Fast Movers."

23 Is that an area that you have
24 within your store?

1 A. We do not.

2 Q. At the bottom of the page, there's
3 an area that says "Final Verification."

4 Is that different than what we
5 already talked about?

6 A. It is. Yes.

7 Q. Okay. And what is the final
8 verification process?

9 A. So final verification is also a
10 pharmacist. It does not have to be the same
11 pharmacist that checked the prescription and
12 data verified the prescription. This is just
13 verifying that the correct medication goes into
14 the bag and then to the patient.

15 So at final verification, I
16 would -- the prescription has already been
17 filled by the technician. I would scan the
18 bottle. At my computer, the prescription will
19 come up at my screen. I can see an image of the
20 drug in the bottle. I verify that picture to
21 what is in the bottle.

22 At this time, I also would verify
23 the quantity. I would eyeball the quantity and
24 make sure it looks like this amount is in the --

1 that was written on the label is in the bottle.
2 For a controlled medication, I -- any controlled
3 medication, I would verify that it was double
4 counted, where our technician will put their
5 checkmarks next to the quantity to show that
6 it's been double counted.

7 For a C-II prescription, we
8 also -- the technician double counts. They also
9 back count the stock bottle that they're given,
10 and that number is written down. And then the
11 pharmacist will also double count -- physically
12 count a C-II, a Schedule II drug. And then we
13 also put our initials at the quantity on the
14 label showing that we double counted it.

15 There's also a prompt on our
16 screen that makes us double count, that says
17 that we double counted. So we check that off
18 before I can put in my biometrics.

19 And then once I do that, the
20 screen will also come up with our perpetual
21 inventory, which is our running inventory of all
22 the C-IIIs that we have. And I put in the amount
23 that we have left in the stock bottle and in the
24 safe, make sure that that is the same. And then

1 it will let me finish checking that
2 prescription.

3 At that point, I would check the
4 prescription number and the patient name to
5 verify that it's all going in the correct bag
6 with the correct label, and then it's ready to
7 be picked up by the patient.

8 Q. Okay. And that process that we've
9 kind of gone through over the course of the
10 morning from a prescription being presented and
11 the data being entered through this final
12 verification where the prescription is ready to
13 go to the patient, about how long does that
14 process take from start to finish specifically
15 for a controlled substance?

16 A. I'm not sure. All of our
17 prescriptions go into our queue time related.
18 So it just depends on when the patient is coming
19 back to pick up the prescription. So this whole
20 process could go over a longer period of time,
21 depending on when that prescription is due to be
22 filled.

23 Q. Okay. Sorry. I was going to say
24 that's a fair answer.

1 So let's go under the assumption
2 that the patient drops it off and tells you
3 they're waiting. I presume those are the
4 prescriptions that you probably put at the top
5 of the queue as opposed to the person that's
6 coming back the next day, right?

7 A. Right.

8 Q. Okay. So if you have --

9 A. We need to give a wait time of
10 ten -- I mean, we could probably do one
11 prescription in ten minutes or so is an adequate
12 time to make sure. Not all of them get done in
13 ten minutes. If there's any problems or any of
14 those issues with calling the doctor that I
15 mentioned before, so -- but I would say we could
16 have a waiter -- a waiting prescription out to
17 the patient most of the time in 10 to 15
18 minutes.

19 Q. Okay. So obviously there could be
20 anomalies or different circumstances that may
21 come up during the verification process, but
22 generally speaking, if everything goes smoothly,
23 a person who drops off a prescription for a
24 controlled substance and says they're going to

1 be waiting should be able to get that
2 prescription filled within ten minutes; is that
3 fair?

4 MR. MAZGAJ: Objection to form,
5 misstates testimony.

6 A. Yes. We can do that -- any
7 prescription in that time. Yes.

8 Q. Okay. We've covered some of this
9 already, but I want to talk a little bit more
10 about some of the workflow process. So I think
11 we're on page 6 now. Can you just flip one page
12 to page 8 if it's double-sided. It should be
13 just one page. You can see at the top of the
14 page it says "Workflow."

15 A. Uh-huh.

16 Q. And then in the box down below, it
17 has a -- you know, a visual of some of the steps
18 that we just went through as far as drop-off,
19 data entry, data verification, final
20 verification.

21 Do you see all of that there?

22 A. Yes. I see it.

23 Q. The first thing that Giant Eagle
24 put under the Workflow section, it says, "Many

1 of our pharmacies are very busy and sometimes
2 hectic places."

3 Do you see that?

4 MR. MAZGAJ: Objection. The
5 document speaks for itself.

6 A. Where is that?

7 Q. The very first sentence under
8 Workflow.

9 A. Oh, okay. I see. I'm sorry. I
10 was looking at the graph -- or the chart. Okay.

11 Q. Yeah. Do you see that under
12 Workflow where it says, "Most of our pharmacies
13 are very busy and sometimes hectic places"?

14 A. Yes, I see that.

15 Q. Okay. Do you agree with that
16 statement that Giant Eagle put into this manual
17 talking about their pharmacies?

18 A. I think over the course of the
19 day, it can be busy and not busy. I don't think
20 it's hectic, but I -- I do believe that we are
21 busy all day, and that a good thing. I like
22 that we are working and we're helping. So, yes,
23 we are busy, but not hectic.

24 Q. Okay. You've told us about

1 filling prescriptions. What other pharmacy
2 tasks do you have that you have to complete
3 during the course of a day outside of filling
4 prescriptions?

5 A. Well, right now we're right in the
6 middle of a pandemic. So we are giving COVID
7 shots to our community, which is great. So we
8 do that every day during the week, Monday
9 through Friday. We -- my store in particular
10 gives the vaccine between 1:00 and 3:00 Monday
11 through Friday, and it works out really well.
12 We also do other immunizations. We pretty much
13 can do most adult immunizations and children as
14 well.

15 We also have medication therapy
16 management, MTM, where it's nice, we can call --
17 we have a program -- Outcomes is what it's
18 called -- where we can find patients, and
19 insurance companies partner with these companies
20 so that we can offer counseling to them. So we
21 call them and do counseling on all of their
22 medications. We can suggest changes to therapy
23 based on what they tell us, and we can contact
24 the doctor for those.

1 Those are just a few of the things
2 that we do.

3 Q. And do you get input from
4 corporate as far as the amount of immunizations
5 you should be trying to accomplish in any given
6 time period?

7 A. We have targets, goals for the
8 year per pharmacy, that corporate does put out
9 for us. It's just more of -- yeah, a goal for
10 us to get to, so ...

11 Q. Okay. And who can give the
12 immunization shots? Is that pharmacists or
13 techs, or all of the above?

14 A. Pharmacists can, and then interns
15 can under the pharmacist. So as long as we're
16 there to help, we can -- we can supervise them
17 giving it.

18 Q. Okay. As far as the MTMs, the
19 medication therapy management, likewise, do you
20 get goals or quotas given to you from corporate
21 as far as how much of that activity should be
22 performed per store?

23 MR. MAZGAJ: Objection to form.

24 A. Yes. We do have goals for that as

1 well.

2 Q. Okay. And who's doing that job?

3 Is that another thing that the pharmacist is
4 doing, or is that something that a tech is
5 doing?

6 A. It depends. It is the pharmacists
7 ultimately. Sometimes technicians can make the
8 calls if -- to check in. One being the example
9 if we filled an antibiotic for a patient, they
10 can call and check -- call the patient a few
11 days later to see how the medication is going.
12 If they have questions, then they would be
13 referred to the pharmacists.

14 Q. Okay. So the pharmacists are
15 filling prescriptions. They're giving
16 immunizations with goals from corporate in mind.
17 They're doing MTMs with goals from corporate in
18 mind. What other tasks are the pharmacists
19 doing while they're on the clock?

20 MR. MAZGAJ: Objection; misstates
21 testimony.

22 A. I mean, I have schedules to write.
23 I have people to hire. I can answer questions
24 from patients that come into the pharmacy. I

1 still help where needed. If we have techs on
2 break, I like to ring register. I'm on the
3 phone with doctors' offices calling for refills,
4 with questions. Insurance billing and issues I
5 can do as well.

6 There's always something to do.

7 Q. Okay. Any other tasks that you
8 can think of -- and not necessarily you, because
9 I know you're the manager, but any other tasks
10 that the staff pharmacists are participating in
11 outside of the ones that you've told us about
12 already?

13 A. I mean, if the pharmacist is in --
14 I mean, it depends on who the pharmacist is
15 working, but they're equipped to handle
16 anything, even if it's directed towards me.
17 Even hiring, my staff pharmacist can do that as
18 well if I'm not there. So they're there to me
19 and the pharmacy.

20 Q. Can you flip with me, please, to
21 page 60 of the document you have there. And let
22 me know when you're there.

23 A. I'm there.

24 Q. Okay. And this -- the title at

1 the top of the page is "Introduction to
2 Drop-off." I wanted to ask you a couple
3 questions about the type of information that you
4 collect when a new prescription is dropped off.
5 So I think you've already told me about date of
6 birth and allergies and also the name.

7 Is there any other information
8 that you would get from a new patient who's
9 dropping off a new prescription?

10 MR. MAZGAJ: Objection to form.

11 A. We collect their name, their date
12 of birth, allergies, their address, phone
13 number, their insurance information.

14 Q. Do you take any type of medical
15 history when a new patient comes in with a new
16 prescription?

17 A. We take their allergies to
18 medications.

19 Q. Okay. Anything other than that?

20 A. No.

21 Q. Okay. Do you require
22 identification?

23 A. We -- a lot of patients do give us
24 their ID to fill in that information, but we

1 don't require it.

2 Q. Do you get any type of
3 prescription history from a new patient? Is
4 that something that you collect?

5 A. If it is a new patient --

6 MR. MAZGAJ: Objection to form.

7 A. If it's a new patient, usually the
8 pharmacist checking the prescription will make a
9 note of that and counsel the patient if that
10 medication list is not dropped off with it,
11 which isn't always the case.

12 Most of the time now we -- most
13 patients do give all of their prescriptions or
14 drop off all of their prescriptions, or at least
15 the med list if it's something new, at the data
16 verification screen.

17 Another -- in the DURs, we can see
18 some -- if there's a medication that they
19 received somewhere else, it will tell us if
20 there's an interaction with that drug so we can
21 see if it -- based on the insurance, what other
22 medications they're on. And if it flags, we can
23 counsel them as well.

24 Q. Okay. So my question is a little

1 bit different.

2 I'm asking whether or not there's
3 a requirement that you ask the patient who
4 brings in -- who's a new patient, brings in a
5 new prescription, whether or not there's a
6 requirement that the Giant Eagle tech or
7 pharmacist ask them about a prescription
8 history.

9 A. No, there's no requirement.

10 Q. Okay. Is a new patient who brings
11 in a new prescription asked questions about any
12 chronic conditions they may have?

13 A. No.

14 Q. Okay. Does -- you know, you've
15 told us a couple of times that nowadays you
16 probably get more prescriptions, you know,
17 e-prescriptions.

18 Is that -- that's fair?

19 A. Right.

20 Q. Is there any type of -- once you
21 get an e-prescription from a new patient, is
22 there any step in the process where you contact
23 that patient and collect additional information
24 from them, or does the process start with just

1 the information that is provided in the
2 e-prescription?

3 MR. MAZGAJ: Objection to form.

4 A. I think -- I don't -- the
5 prescription doesn't really -- it gets entered
6 in by a technician. We take the information
7 that we need to put them into the system. If a
8 pharmacist at the data verification process has
9 a question on any of those things, that's when
10 we would either call the patient or call the
11 prescriber to get that information.

12 Q. Okay. Flip, if you would, please,
13 to page 62. And in the middle of the page,
14 there's an entry that says "Presorted Promise
15 Time Organization."

16 Do you see that?

17 A. Yes.

18 Q. And underneath there, it says,
19 "There are three baskets at drop-off. One
20 basket is for waiting prescriptions, one basket
21 is for prescriptions to be picked up later in
22 the day, and the third basket is for
23 prescriptions to be picked up tomorrow or
24 later."

1 Do you see that?

2 A. Yes.

3 Q. Is that the system that is still
4 used at Giant Eagle and particularly at your
5 store?

6 A. No, it is not.

7 MR. MAZGAJ: Objection.

8 Q. Okay. Was that procedure ever
9 used at your store or a store that you worked
10 at?

11 A. Yes. It was before -- I don't --
12 this must be really -- this is old. I don't
13 know. I barely -- I remember this, but I barely
14 remember this, so ...

15 Q. Okay. Go down to the second
16 paragraph that starts with "The PPT time."

17 Do you see that?

18 Are you with me?

19 A. Yes.

20 Q. Okay. It says, "The PPT time is
21 standardized in stores. Waiting prescriptions
22 are assigned a PPT time of 15 minutes from
23 drop-off, and later prescriptions are assigned
24 to be completed 90 minutes from drop-off."

1 Do you see that?

2 A. I see that.

3 Q. Okay. Is there a presorted
4 promise time or any type of promise time system
5 in place at your store at Giant Eagle now as far
6 as a communication that's standard to the
7 customer about how long it will take to fill
8 their prescription?

9 MR. MAZGAJ: Objection to form.

10 A. There's nothing -- I don't -- I
11 don't know what this is, but the -- right now
12 our system allows us to select "urgent waiting."
13 I believe there's "e-script." There's a "today"
14 selection. There's a "future date." And then
15 there's a "future two-day." I think that's all
16 of them.

17 I don't -- I know -- I think
18 urgent immediately shows up. We have color
19 codes. Urgent immediately shows up as red in
20 our system and will be prioritized to the top of
21 our queue.

22 Waiters will be right below urgent
23 in our system and are prioritized in our queue
24 that way. Today I think is an hour or so.

1 E-scripts might still be 90 minutes if they come
2 through. And then future date obviously is
3 tomorrow. Usually, like, the next day -- next
4 business day after 12:00, because they might be
5 filled at our off-site pharmacy.

6 So, yes, we have things like that
7 built into the system to prioritize the work.

8 Q. Okay. And so with those -- so
9 what it sounds like is the prescriptions are
10 classified based on when the patient needs the
11 prescription?

12 A. Yes. We ask them when they drop
13 off the prescription or the -- if they're
14 e-prescribed, our system has something in place
15 where maintenance medications will usually be
16 put to the next day, and prescriptions that are
17 more of an urgent need are prioritized for that
18 day to be filled.

19 Q. Okay. And you mentioned some
20 times for some of the different types of
21 classifications. So what is the time that a
22 waiter is supposed to be able to have their
23 prescription filled?

24 A. I can't remember how long that is,

1 honestly, in the queue. They get put to the top
2 anyway of our queue. So they're usually dealt
3 with in the time that's needed, but I can't
4 remember what time is actually assigned to it.

5 Q. Okay. Well, what is the time that
6 an urgent prescription is supposed to be able to
7 be filled?

8 A. That's just automatically put to
9 the top of our queue. So it's -- urgents go
10 above waiting. So they're just the one that --
11 it will automatically go to the top of anyone's
12 work queue so that it's dealt with first.
13 There's no time on that.

14 Q. Okay. And you said that these
15 prescriptions will be color coded based on the
16 time in which the customer has indicated that
17 they need the prescription to be filled?

18 MR. MAZGAJ: Objection to form.

19 A. We have like a bar at the top of
20 our screen for how much -- which prescriptions
21 are in which queue. So if you are behind on
22 that time, it will -- if you're all on time,
23 it's green. And then it will turn to red if
24 you're overdue for that time period.

1 Q. Okay. So you -- okay. I'm just
2 trying to visualize this, and maybe we'll see a
3 screenshot of it later and that will help us,
4 but I didn't see one when I was looking at some
5 of this material.

6 So what screen or dashboard is
7 this where you're seeing the queue? Is this
8 just on the normal computer screen, or is this
9 somewhere else within the pharmacy?

10 A. It's just the main screen on our
11 EPS program. So it will -- it has like a -- it
12 shows how many prescriptions are in product ver,
13 how many are in fill, how many are in data entry
14 and data ver. There might be a few other boxes,
15 but those are the ones that we pay attention to.
16 And it just shows how many are in there
17 throughout the day.

18 Q. Okay. And are all of those
19 different scripts that you may see in the
20 different stages of being filled, are they all
21 color coded based on whether or not it's a
22 waiter, or whether or not it's urgent or whether
23 or not it's an e-script?

24 A. Yes. Every prescription is coded

1 in one of those buckets.

2 Q. Okay. Does each individual script
3 that you can see in each stage of the process
4 have a clock on it or any type of timer on it
5 that you can see so that you can know where you
6 are in the process?

7 MR. MAZGAJ: Objection to form.

8 A. So, like, up in the top corner, it
9 will show -- like if something flips to red like
10 it's waiting, I believe it gives, like, how
11 overdue it is, but we don't -- we don't really
12 look at that.

13 Sometimes -- I mean, even if you
14 put something in our call queue that was a
15 waiter but we had a question on it, when we get
16 that question answered and put it back into our
17 workflow, it still has the time on it from a day
18 ago that -- when it was a waiter. It still has
19 that same time associated to it. So, you know,
20 it could say a day overdue just by putting it
21 back into workflow.

22 So we don't really look at the
23 timing of it, more than the system sorts it for
24 us. Whether -- you know, if it's -- I more look

1 at what's waiting that people are coming in
2 today for and what is future dated that we don't
3 have to address it right away, if that makes
4 sense.

5 Q. Okay. I'm not sure if you
6 answered my question or not. So let me try it
7 one more time.

8 For each script that you can see
9 at different stages, can you see a clock or a
10 timer on each script or -- you've already told
11 us that you see an overall status bar at the top
12 that is either green or switches to red if you
13 get behind.

14 So my question is about each
15 individual script. Can you see a timer or a
16 clock on each of them?

17 A. No, there's no timer or clock on
18 the prescription. If I looked in each
19 individual queue, it would probably have the
20 time associated with whatever bucket you're in,
21 so that would probably be the only way to look
22 at what time it's due.

23 Q. Okay. And as far as the overall
24 status bar, that's at the top of this screen?

1 MR. MAZGAJ: Objection to form.

2 A. There's no time. I mean, it might
3 say something is overdue. But like I said, I
4 don't -- I don't really look at that. I look at
5 the buckets in front of me. If I'm red, then I
6 know I need to do -- to catch up.

7 Q. And I might be asking bad
8 questions. I'm not trying to figure out what
9 you're looking at or what you're focusing on.

10 I'm trying to understand what the
11 system looks like and what it displays, because,
12 you know, there's many -- many folks that work
13 at Giant Eagle. I've never seen this screen
14 before.

15 So that's what I'm trying to get
16 an understanding of, is what it looks like and
17 what it's displaying. And then we can talk
18 later about where you focus your attention.

19 But this status bar that you've
20 said is either green or red that tells you where
21 you are or how you're doing based on your queue,
22 where is that status bar?

23 MR. MAZGAJ: Objection; misstates
24 testimony.

1 A. The bar is at the top of the
2 screen. And then I have my main bar in the
3 middle of the screen that shows what's in each
4 bucket, data entry, data ver.

5 Q. Okay. So at the top of the
6 screen, there's a horizontal bar that goes
7 across the screen, correct?

8 A. Right.

9 Q. Okay. And what are the options
10 for what color that bar could be?

11 A. Green, yellow, red.

12 Q. Okay. What does green mean?

13 A. It means that you're caught up
14 with what you're doing. It's -- nothing is
15 overdue. You're on time.

16 Q. What does yellow mean?

17 A. I'm not really sure. I would say
18 it's probably close to a wait time, but -- I
19 think. I don't know what that constitutes,
20 yellow, but that's my guess.

21 Q. What does red mean?

22 A. That you're overdue for a wait
23 time.

24 Q. Okay. Other than the bar turning

1 red, is there any other way that you and the
2 other pharmacists or the other pharmacy techs
3 are notified that you're behind? Is there --
4 does it flash? Is there a beep? Is there an
5 e-mail that comes out that's standardized, or
6 anything else that happens to tell you you're
7 behind?

8 MR. MAZGAJ: Objection; misstates
9 testimony.

10 A. No, there's nothing else.

11 Q. Okay. What do y'all within the
12 store -- if you were to communicate to another
13 pharmacist or a tech that the bar has turned
14 red, how would you say that to somebody else in
15 the store?

16 A. That we're in the red, so -- or
17 fills in red.

18 Q. Okay. And if somebody says,
19 "We're in the red" or "Fills in red," what does
20 that mean?

21 A. That we need to do what we can to
22 help, whatever it may be. So if data entry is
23 in red, the help pharmacist or the help
24 technician would concentrate on getting those

1 prescriptions entered into the system.

2 If fill was in red, we might have
3 another one of our technicians that typically
4 data enters to prioritize filling for about 10
5 or 15 minutes, something like that.

6 Q. And is the time that it takes to
7 fill a prescription something that is monitored
8 by Giant Eagle corporate as far as one of the
9 metrics that they look at for stores?

10 MR. MAZGAJ: Objection to form,
11 assumes facts.

12 A. I don't know. I've never -- I've
13 never had them ask me about that. So I -- I
14 don't think so.

15 MR. MAZGAJ: Emily, we've been
16 going another hour. How are you doing?

17 THE WITNESS: I could use a
18 bathroom break.

19 MR. GADDY: Sounds good.

20 THE VIDEOGRAPHER: Off the record,
21 1:57 p.m.

22 (Recess taken.)

23 THE VIDEOGRAPHER: On the record,
24 2:04 p.m.

1 - - -

2 (Mooney Deposition Exhibit 2 marked.)

3 - - -

4 BY MR. GADDY:

5 Q. Ms. Mooney, I'm going to turn now
6 to a document that would have been delivered
7 this morning. It's document P-HBC-1432. I
8 think if you look at the upper right-hand
9 corner, it's going to be one of your performance
10 reviews.

11 And let me know when you've found
12 the one that says 1432.

13 A. Got it.

14 Q. Do you see at the top of the page,
15 it says, "Annual Performance Review" for you,
16 for Emily K. Mooney?

17 A. Yes.

18 Q. Okay. And you have -- you undergo
19 performance reviews at Giant Eagle on a periodic
20 basis, right?

21 A. Annually, yes.

22 Q. Okay. Annually. And I guess you
23 have an understanding that you are evaluated
24 based on certain criteria that Giant Eagle

1 corporate has proposed; is that right?

2 A. Yes.

3 Q. Okay. And I've had the
4 opportunity to review a couple of these, and it
5 looks like the format that I understand it to be
6 in is corporate has proposed a criteria. They
7 propose a way to measure whether or not you were
8 successful with what they propose, and then you
9 actually see the results as far as whether or
10 not you actually met that goal.

11 Does that sound about right?

12 MR. MAZGAJ: Emily, take your time
13 to review the document if you need to.

14 THE WITNESS: Okay.

15 A. Yes.

16 Q. Okay. And then it also looks like
17 there's a place where you get to make some
18 comments about your performance on any
19 particular goal, correct?

20 A. Yes.

21 Q. Okay. And let's just look at the
22 very first one up on -- up on the page. You see
23 about halfway down it says, "Respect for team
24 members."

1 A. Yes.

2 Q. Okay. And it says -- under "What
3 will you do," it says that the goal there was to
4 "improve customer safety."

5 Do you see that?

6 A. Yes.

7 Q. And then the next section asked
8 how you'd measure that goal and it says,
9 "Eliminate quality policy violations," and it
10 has some examples there, and it says, "Execute
11 all quality improvement measures."

12 Do you see that?

13 A. Yes.

14 MR. MAZGAJ: Objection to form.

15 Q. And then over on the right -- to
16 the right of that, it asks, "What actually
17 happened?" And it gives the results of your
18 performance on that particular metric.

19 Do you see that?

20 A. I do.

21 Q. And then below -- just below that,
22 we see the date range that this is for. I'm not
23 sure why that wasn't at the top of the page.
24 But it looks like this time period that you're

1 being evaluated here is between July of '13
2 through June of '14.

3 Do you see that?

4 A. Uh-huh.

5 MR. MAZGAJ: Objection to form.

6 Q. I'm sorry, Ms. Mooney. You've got
7 to say yes or no.

8 A. Yes.

9 Q. Okay. And then just below that,
10 it says you did a self evaluation, indicated
11 that you had met expectations. And then below
12 that, you got to enter a comment saying that you
13 and your store significantly improved where it
14 comes to customer safety, eliminating MedSelect
15 and point-of-sale errors.

16 Do you see that?

17 A. I do see that.

18 Q. Okay. And that's the type of
19 process that you would go through for each of
20 these criteria that corporate has spelled out
21 for you to be evaluated on on your annual
22 performance review, correct?

23 A. Yes.

24 Q. Okay. Turn the page, if you

1 would.

2 MR. MAZGAJ: Jeff, before we --
3 Jeff, is this meant to be Exhibit 8?
4 This is the second one you've entered,
5 right? I just wanted to make sure I'm
6 not missing anything.

7 MR. GADDY: Yeah. Thanks. We'll
8 mark this as Exhibit Number 2.

9 MR. MAZGAJ: Okay. Great. I just
10 wanted to make sure I wasn't missing
11 anything. Thank you.

12 BY MR. GADDY:

13 Q. If you'd turn with me, please,
14 Ms. Mooney, to the second page. Do you see in
15 the middle of the page, there's a section that
16 says "Operational Excellence"?

17 A. Okay.

18 Q. And do you see that the goal
19 that's been provided there is "Improve customer
20 satisfaction."

21 Do you see that?

22 A. Yes, I see that.

23 Q. And then when it asks how you will
24 measure the success with this goal that's been

1 provided by corporate, it says, "Achieve overall
2 satisfaction goal for the store." It says,
3 "Achieve pharmacy overall satisfaction goal.
4 Achieve overall satisfaction for pharmacy core
5 experience focus areas," which it lists as
6 "friendliness" and the "time to fill
7 prescription."

8 Do you see that?

9 MR. MAZGAJ: Objection; assumes
10 facts not in evidence.

11 A. Yes, I see that.

12 Q. Okay. Do you recall that during
13 the fiscal year from July '13 through June of
14 '14, that one of the things corporate was
15 evaluating you on was your performance on scores
16 related to the time to fill a prescription?

17 MR. MAZGAJ: Objection to form.

18 A. I see that they put that in as a
19 marker, but that's one piece of a score. These
20 surveys from the patient has a few things that
21 they answer survey questions about. It's a
22 grocery store. Every department has these
23 customer satisfaction scores. It's listed this
24 far down for a reason.

1 I mean, our patient safety is the
2 number one goal with Giant Eagle and for the
3 company. That's why it's listed first. I mean,
4 my safety is meets expectations.

5 This is just one piece of the
6 grocery store part -- I mean, we are a grocery
7 store, so that is -- that is a focus, is
8 customer service, yes, but not at the expense of
9 safety.

10 MR. GADDY: Okay. I'm going to
11 move to strike that as nonresponsive.

12 BY MR. GADDY:

13 Q. Ms. Mooney, my question is whether
14 or not you see that one of the criteria that
15 corporate was evaluating you on during this time
16 period was the time to fill a prescription.

17 Do you see that?

18 A. Yes, I see that, and --

19 Q. Okay. And do you have a general
20 understanding that that was a metric that
21 corporate was looking at and that they were
22 getting feedback from their customers on whether
23 or not they were happy with the time it took for
24 the pharmacy to fill a prescription.

1 Did you have a general
2 understanding of that?

3 MR. MAZGAJ: Objection;
4 foundation.

5 A. I don't -- I don't know. I mean,
6 it's a metric here. I'm not -- I don't remember
7 that being a metric. It's not a focus of mine.
8 It's part of a review. So that would not have
9 been a focus of mine on this review.

10 Q. Okay. I'm not asking if it was a
11 focus of yours.

12 I'm asking whether or not you are
13 aware by seeing it on this evaluation and by
14 making comments regarding this evaluation that
15 it was a metric that corporate was tracking
16 about whether or not customers were satisfied
17 with the time it took for your pharmacy to fill
18 a prescription?

19 Were you aware of that?

20 A. I -- this document has made me
21 aware of this. I see it. Yes, I can read that.

22 Q. Okay.

23 And over in the section that says
24 "What actually happened," it has a couple scores

1 at the top, and then it says, "Time to fill
2 prescription was 66 percent over current three
3 months' period up 13 percent from the previous
4 three months."

5 Do you see that?

6 MR. MAZGAJ: Objection to form.

7 A. I do see that.

8 Q. So it looks like in this
9 evaluation, your pharmacy had improved their
10 score when it came to customer satisfaction with
11 the time it took to fill a prescription.

12 Do you see that?

13 A. I see what's written there, yes.
14 I don't -- I can read it.

15 Q. Okay. Did your pharmacy district
16 leader ever speak with you or any of the other
17 pharmacists about the types of metrics that
18 corporate was using to evaluate you and evaluate
19 your pharmacy?

20 MR. MAZGAJ: Objection;
21 foundation.

22 A. This -- this review was done by my
23 store manager. This isn't my PDL. So this
24 is -- this is the manager of the store, Lisa.

1 So, no, my PDL did not speak with me about this.

2 Q. Okay. I'm sorry. I wasn't asking
3 in the context of this document. I was asking
4 generally.

5 Did your PDL ever speak with you
6 or other pharmacists about the metrics that
7 corporate was evaluating from your store?

8 MR. MAZGAJ: Objection; compound,
9 lack of foundation.

10 A. No, not that --

11 Q. I'm sorry. We keep talking over
12 each other.

13 A. I said I'm not aware of my PDL
14 talking to me about this, no.

15 Q. Okay. Were you aware of the fact
16 that there were metrics that corporate was
17 looking at for your pharmacy?

18 MR. MAZGAJ: Objection; assumes
19 facts, lack of foundation.

20 A. We have a customer service score.
21 What metrics -- I don't understand what you're
22 asking. I'm sorry.

23 Q. That's fine.

24 So my question is whether or not

1 you are aware that corporate was reviewing
2 metrics from your store in whatever form that
3 was.

4 MR. MAZGAJ: Objection; lack of
5 foundation, assumes facts.

6 A. I mean, corporate does track
7 metrics. I don't -- I don't know which ones --
8 I'm not -- I wasn't aware of them tracking time
9 to fill, if that's what you're asking.

10 Q. What metrics does corporate track
11 that you're aware of?

12 MR. MAZGAJ: Objection; form.

13 A. From a performance review, I
14 don't --

15 Q. I'm not asking in the context of
16 performance review. You just said, "I mean
17 corporate does track metrics," and I'm asking
18 what you have an understanding of that corporate
19 tracks regarding your pharmacy.

20 A. I know they track my
21 prescriptions, my labor, what -- how many
22 immunizations I do. The amount of incidents for
23 safety is important. That's usually -- the more
24 pharmacy related is what I'm really looking for

1 and what I am more aware of. There's the safety
2 of the customer. I mean, and then the typical
3 business markers that are listed here as well.
4 I mean, what is listed here is what they track.

5 Q. Okay. And can you flip the page
6 for me, please, to the Bates number on the
7 bottom right-hand corner that says -- ends in
8 156.

9 A. Okay.

10 Q. And do you see in the middle of
11 the page it says, "Profitable Growth."

12 A. Yes.

13 Q. And below that, another facet that
14 corporate was evaluating you on was whether or
15 not there was an increase in store operating
16 profit.

17 Do you see that?

18 MR. MAZGAJ: Objection; misstates
19 the document.

20 A. That's the goal, to increase store
21 operating profit.

22 Q. Okay. And that was a goal that
23 you as the pharmacy manager for the pharmacists
24 were being evaluated on here by Giant Eagle,

1 correct?

2 A. That is the goal, yes.

3 Q. Okay. And then when it asks how
4 are you going to measure that, it says, "Achieve
5 actual versus budget operating profit for the
6 store."

7 Do you see that?

8 A. Yes.

9 Q. Then there's some entries over on
10 the right regarding the budget and the actual
11 profit, indicating that it looks like you came
12 up \$13,000 short of the budget for the operating
13 profit that you were shooting for.

14 Do you see that?

15 MR. MAZGAJ: Objection to form.

16 A. Right.

17 Q. Okay. And in the next entry down,
18 do you see the next goal is to "Increase sales"?

19 A. Okay.

20 Q. And the -- how that is going to be
21 measured is whether or not you achieve the sales
22 target goal for the store.

23 Do you see that?

24 MR. MAZGAJ: Objection; misstates

1 the document.

2 A. I do.

3 Q. Okay. And over to the right, when
4 it asks what actually happened, it indicates
5 that the Rx sales -- what does "Rx" mean?

6 A. That is our prescription sales.

7 Q. Okay. So it says, "The
8 prescription sales were over \$5.4 million."

9 Do you see that?

10 A. I see that.

11 Q. And your budgeted sales were
12 5.3 million, and you notice -- noted that you
13 met and exceeded your goal by over 2 percent.

14 Do you see that?

15 MR. MAZGAJ: Objection; misstates
16 the document.

17 A. I see the difference in the
18 2 percent, yes.

19 Q. Okay. And you rated yourself,
20 said -- gave yourself a 3, that you met the
21 expectations, or you said the store was close to
22 target sales. The "pharmacy exceeded budgeted
23 sales for fiscal year 2014 which was a great
24 improvement over fiscal year 2013."

1 Do you see that?

2 A. I see that.

3 Q. If you flip to the top of the next
4 page, I want to look at the next facet on which
5 Giant Eagle was evaluating you as a pharmacist.
6 At the top of the page, do you see where it says
7 "Increase Script Volume"?

8 A. Yes.

9 Q. And that was the goal that was
10 presented here that Giant Eagle corporate was
11 evaluating you on, correct?

12 MR. MAZGAJ: Objection; misstates
13 the document.

14 A. The increased script volume, I see
15 that, yes.

16 Q. Okay. And the way to measure that
17 was they were asking you to achieve an increased
18 script volume over the previous year.

19 Do you see that?

20 MR. MAZGAJ: Objection; misstates
21 the document.

22 A. Yes. We were just increasing the
23 volume over last year. Yes, I see that.

24 Q. Okay. And then over on the

1 right-hand column as far as "What actually
2 happened," it indicates that the total
3 prescriptions filled were 126,000 and change,
4 which fell a little bit short of the budgeted of
5 133,000 and change.

6 Do you see that?

7 A. I do see that.

8 Q. Okay. So corporate had given you
9 a goal of filling 133,326 scripts during this
10 fiscal year, and it looks like you fell just
11 short of that.

12 Do you see that?

13 A. I do see that.

14 Q. Okay. And down here in the
15 comments, it looks like you provided what looks
16 to be a reasonable explanation. You said,
17 "While scripts have decreased, we discontinued
18 free antibiotics and diabetic medications in the
19 last year. I believe this is responsible for
20 the decrease in prescriptions."

21 Do you see that?

22 A. I do see that.

23 Q. You go on to say that "Since our
24 sales have increased, I believe this number" --

1 meaning the script number -- "does not have the
2 same weight as in previous years."

3 Do you see that?

4 A. Yes, I see that.

5 Q. Could you turn with me, please, to
6 the Bates ending 159.

7 Down at the bottom of the page, it
8 says, "Level 3 Dealing with Ambiguity."

9 Do you see that?

10 A. I do.

11 Q. Okay. And I'm really just going
12 to ask you about the comment that you made
13 there. You say, "Every day is different in the
14 pharmacy. If you can't multitask, your
15 pharmacy" -- and you say "with." I think you
16 meant "will."

17 But it says, "Every day is
18 different in the pharmacy. If you can't
19 multitask, your pharmacy will struggle."

20 Do you see that?

21 A. I do believe you need to
22 multitask, yes.

23 Q. Okay. You go on to say, "I'm
24 lucky to have a good group of pharmacists that

1 can do this effectively."

2 Right?

3 A. Right. I do have a good team.

4 Q. What do you mean when you say that
5 as a pharmacist, if you can't multitask, the
6 pharmacy will struggle?

7 A. I believe that you need to be able
8 to do many things and focus on many things.
9 That's what a pharmacist does. We're dealing
10 with customers, insurance, prescribers, and
11 checking prescriptions, and we need to do that
12 in a safe way.

13 So it's really important to be
14 able to multitask, to prioritize tasks, to make
15 sure that we get the correct medication to the
16 patients and to keep them safe.

17 So there's a lot that we have to
18 do, but it's something I enjoy doing and so do
19 the people that I work with. So it's -- it's
20 not difficult to be able to do what is asked of
21 us and what I want to do as a pharmacist and go
22 over and above to do this.

23 So I absolutely agree. If you
24 can't multitask, if you're not willing to do

1 that and work for that, it is a struggle, but
2 I'm looking up. I don't have to worry about
3 that.

4 Q. Ms. Mooney, I think you might have
5 some papers on the microphone. We're getting a
6 lot of feedback from you.

7 A. Sorry.

8 Q. No, that's fine. I just -- I know
9 it's hard for Carol sometimes to hear.

10 Now, from a general perspective,
11 you have an understanding that your performance
12 on these annual performance evaluations can
13 impact your pay and your advancement at Giant
14 Eagle; is that fair?

15 MR. MAZGAJ: Objection to form.

16 A. I disagree with that. I think
17 that they -- the performance review, from what I
18 understand, does not have -- that I know of,
19 have any effect on my pay. It might have to do
20 with advancement, but I've never seen it have to
21 do with my pay.

22 Q. Okay. So let me ask it a little
23 bit differently.

24 You have a general understanding

1 that your performance on these annual
2 performance reviews can impact your career at
3 Giant Eagle as far as how you progress through
4 the company or other aspects of your job at
5 Giant Eagle?

6 MR. MAZGAJ: Objection; compound.

7 A. I see these reviews as being
8 something that I can improve on for myself year
9 to year.

10 I get feedback from my -- from
11 whomever is doing the review for me, and then
12 use that to grow over the next year. So I see
13 these more as a review just of myself and how to
14 do better.

15 Q. Okay. Do you have a general
16 understanding that your performance on these
17 reviews can impact your advancement through the
18 company, meaning if you do really well, you may
19 have good things happen to you career-wise. If
20 you consistently don't do very well, you might
21 have not-so-good things happen to you
22 career-wise; is that fair?

23 A. I see that.

24 MR. MAZGAJ: Objection to form.

1 A. Since they do generally well, I
2 see it more as something that I can work on on
3 my own.

4 Q. Okay. So was the answer to my
5 question yes, that if you do well, you think it
6 will positively impact your career? If you
7 don't do well, you think it may not positively
8 impact your career?

9 MR. MAZGAJ: Objection;
10 foundation.

11 A. To some extent. I mean, I don't
12 have a lot of -- I mean, anyone that's done
13 these reviews has not explained anything of any
14 weight in affecting where I would go in the
15 company. So I'm not aware of that.

16 Q. Do you strive to meet the goals
17 that are set for you by corporate?

18 MR. MAZGAJ: Objection; form.

19 A. I see those goals as something to
20 look to, yes. That's what a goal is. So I want
21 to do my best, especially when it comes to
22 safety and working with others and making sure I
23 run a good pharmacy and have a good team. Those
24 are important to me. So I focus on a few of

1 these throughout the year.

2 So I use these as something that I
3 can work towards. I usually pick something like
4 safety or the team -- team building as something
5 to do better each year, workflow, things like
6 that.

7 Q. So, yes, you strive to meet the
8 goals that are set for you by corporate?

9 MR. MAZGAJ: Objection; asked and
10 answered.

11 A. I strive to look towards those
12 goals that I just told you, yes.

13 MR. GADDY: Let's look at
14 P-HBC-1440, which is going to be in that
15 same group that was delivered this
16 morning.

17 We'll mark this as Exhibit
18 Number 3.

19 - - -

20 (Mooney Deposition Exhibit 3 marked.)

21 - - -

22 BY MR. GADDY:

23 Q. Tell me when you've found this
24 one, Ms. Mooney.

1 A. Oh, I do. I have it.

2 Q. Okay. And you see this one at the
3 top --

4 MR. GADDY: And, Matt, we got
5 several of these with her Social
6 Security number on it. Obviously, we
7 don't need that. If you want to --

8 MR. MAZGAJ: Oh, sorry about that.
9 Yep. Thank you.

10 MR. GADDY: If you want to swap
11 these out and make a note about that.

12 MR. MAZGAJ: We will.

13 MR. GADDY: And then obviously
14 we'll be fine with that.

15 MR. MAZGAJ: Thank you.

16 BY MR. GADDY:

17 Q. Ms. Mooney, you see this looks
18 like your performance appraisal, it looks like,
19 in fiscal year 2011?

20 A. Okay.

21 Q. And you see it lists you -- at
22 that point in time, you were a floater, correct?

23 A. Yes.

24 Q. Okay. And what I really wanted to

1 ask you about was a couple of the comments.

2 This is on the second page.

3 MR. MAZGAJ: Emily, take the time
4 that you need with the document.

5 THE WITNESS: Okay.

6 Q. Okay. Do you see the comment
7 section on kind of the top half of the second
8 page?

9 A. Yes.

10 Q. You say -- in the first one where
11 it says to describe strengths, you say, "I work
12 well with others, can work in most any
13 environment, busy or slow stores."

14 What do you mean by that?

15 A. The change of pace. I can work
16 well either way, by being busy or slow. I can
17 always find something -- something to do,
18 something to work on.

19 Q. Okay. Again, you reference
20 multitask. You say, "I can multitask." And we
21 looked at that another time, and you've already
22 told us how important that is for a pharmacist,
23 correct?

24 A. Yes, I can multitask. I can do a

1 lot of things. Yes.

2 Q. Okay. In your experience over the
3 course of your career as a pharmacist, have you
4 had the opportunity to see -- whether it's in
5 your own store or maybe it's during the period
6 of time that you were floating and going to 15
7 to 20 stores on kind of a rotating basis, have
8 you had the opportunity to see or come into
9 contact with pharmacists who maybe multitasking
10 was not a strength for them?

11 MR. MAZGAJ: Objection; misstates
12 testimony, foundation.

13 A. No. I mean, for the most part, I
14 think Giant Eagle pharmacists can adapt well to
15 any environment. I haven't had any issue
16 working with anybody. So, yeah, I would say, in
17 general, most pharmacists can do that.

18 Q. Okay. I'm not -- I'm not asking
19 you in general. I'm asking whether or not
20 there's ever been a course during the time while
21 you've been with Giant Eagle that you've run
22 into a pharmacist that you, you know, made a
23 determination that they can't really multitask,
24 and maybe they cut corners. And maybe -- just

1 like there's folks that are high performers and
2 low performers at probably every profession in
3 the world, I'm asking whether or not you've ever
4 run into any low performers as far as
5 pharmacists in the Giant Eagle world.

6 MR. MAZGAJ: Objection; compound,
7 foundation, misstates testimony.

8 A. Yeah, I think I'm -- you're
9 generalizing that -- I mean, I don't -- I don't
10 see any low performers. I mean, Giant Eagle
11 doesn't -- I don't know. Every pharmacist I've
12 worked with does not cut corners, like you said.
13 Absolutely not. We take our jobs really
14 seriously. We have a license to take our jobs
15 seriously. So, no, I don't.

16 Q. Have you in your time ever had to
17 recommend a pharmacist be terminated or
18 disciplined?

19 A. Not that I can recall.

20 Q. Okay. Are you aware of any
21 pharmacist within Giant Eagle ever being
22 terminated?

23 MR. MAZGAJ: Objection; form.

24 Are you talking about for cause

1 or -- I mean -- sorry. Sorry.

2 A. I don't -- I don't know. I mean,
3 I know of people not working for the pharmacy
4 anymore, but I don't know reasons why they're
5 not working. So I don't know if I know of
6 someone terminated.

7 Q. Let me ask you about the next
8 comment that you make on here. It's in the
9 "Developmental Opportunities" section.

10 Do you see that?

11 A. Yes.

12 Q. It says, "I would like to work on
13 better mystery shop scores. Extra mile
14 continues to evade me."

15 Do you see that?

16 A. Yes.

17 Q. Can you explain to me what you're
18 referring to there as far as "mystery shop
19 scores"?

20 A. Yes. Mystery shop was something
21 Giant Eagle used a long time ago, so in 2012,
22 '13, where they would have people come to the
23 pharmacy, ask for, like, a recommendation or a
24 product, or they would be rung out at the

1 pharmacy for something that they bought in the
2 store.

3 Giant Eagle -- I like that they
4 push, you know, customer service, to talk to the
5 customer. So when -- for the pharmacy anyway,
6 we would go out into the store and help the
7 customers. We still do that. It kind of brings
8 us to -- like puts a face to the pharmacist and
9 gets us out into the store to help customers.

10 So it was just kind of like an
11 added step to try to get us out there and
12 working with customers. And then they would
13 score us on -- I'm not sure on what exactly. It
14 wasn't always the pharmacists. It was
15 technicians too that they would focus on.

16 I can't remember exactly what the
17 extra mile is in regards to that, but that was
18 the gist of the mystery shop.

19 Q. Okay. So it was some type of
20 program where somebody would come in undercover,
21 for lack of a better word, pretend to be a real
22 customer, but really they're evaluating how your
23 customer service skills were.

24 Is that a fair description?

1 A. Right.

2 Q. Okay. Has there ever been any
3 program at Giant Eagle that you're aware of
4 where they would do anything with kind of a
5 mystery shopper type context to it where they
6 would present a controlled substance
7 prescription, and that you would be evaluated on
8 kind of your due diligence process or your
9 evaluation of filling that prescription? Are
10 you aware of Giant Eagle ever having a program
11 like that for prescriptions as opposed to
12 picking items off a shelf?

13 A. Absolutely not. I think there's
14 just way too many legal issues with that. I
15 don't even know how you could do something like
16 that, so no.

17 MR. GADDY: I'll move to strike
18 everything after "absolutely not."

19 - - -

20 (Mooney Deposition Exhibit 4 marked.)

21 - - -

22 BY MR. GADDY:

23 Q. There's one more of these I want
24 to look at. Look at P-HBC-1446. It's going to

1 be in the same envelope from this morning.

2 Let me know when you've got it.

3 A. I have it.

4 Q. Okay. Do you see your name at the
5 top left where it says "Pharmacy Team Leader"?

6 A. Yes.

7 MR. MAZGAJ: Take the time you
8 need, Emily.

9 Q. And over on the right-hand side,
10 it has your location number, the 6377,
11 Painesville Supermarket, and it has a date range
12 of July through September 2020.

13 Do you see that?

14 A. Yes, I see that.

15 Q. Okay. I want to ask you about
16 the -- an entry you made on the third page of
17 this document in response to a "Mid-year Focus
18 Question," which is at the top of the third
19 page.

20 MR. MAZGAJ: Emily, have you had a
21 chance to review the document to your
22 needs?

23 THE WITNESS: No.

24 MR. MAZGAJ: Okay. Take your

1 time.

2 BY MR. GADDY:

3 Q. Are you ready, Ms. Mooney?

4 A. Yes.

5 Q. Okay. You see the top of page 3,
6 it says, "Mid-year Focus Question"?

7 A. Yes.

8 Q. And then there's a question, it
9 says, "Consider our core values." It says, "In
10 the comment box below, please describe how you
11 demonstrated these core values in your role."

12 Do you see that?

13 A. Yes.

14 Q. And then under the response, you
15 have five different entries or five different,
16 what I'd call, headings. You say, "Be Kind,"
17 and then a couple lines down, it says, "Think
18 Team," and it says, "Step Up," and it says,
19 "Work Smart," and then it says, "Live Well."

20 Do you see those different
21 headings?

22 A. I do.

23 Q. Okay. And are those some of the
24 core values that it's being referred to at Giant

1 Eagle?

2 A. Those -- yes. At the beginning,
3 yes.

4 Q. Okay. And under the "Step Up"
5 value, you indicated that "I try to encourage my
6 team to take pride in our store metrics and to
7 step up and help."

8 Do you see that?

9 A. I do, yes. In this instance, I
10 was -- I really push the team involvement in the
11 immunizations. So this one in particular, we
12 had a poster, a whole board, made to try to get
13 the whole team involved in getting immunizations
14 out to the community, so that was that one.

15 Q. Okay. And so this was in, it
16 looked like, July to September of last year. So
17 what type of immunizations are you talking about
18 that you were pushing the team to get out and
19 perform?

20 A. Flu shots in particular, but we
21 also have SHINGRIX, the shingles vaccine. Those
22 are -- were our two big ones at that time.

23 Q. And these aren't immunizations
24 that Giant Eagle gives out for free, are they?

1 A. No, they're not.

2 Q. Okay.

3 A. Most of them are covered by
4 insurance, especially the flu shots. There's
5 really no copay on the flu shots. Insurance
6 usually covers that.

7 Q. Sure. And insurance is paying
8 Giant Eagle when they administer these things,
9 correct?

10 A. Yes.

11 Q. Okay. Now, as a pharmacist, you
12 are eligible to receive an annual bonus; is that
13 correct?

14 A. I am.

15 Q. Okay. And are you aware that
16 there's different criteria that are looked at to
17 determine the size of your bonus each year?

18 MR. MAZGAJ: Objection to form.

19 A. I usually get an e-mail every
20 couple years about those metrics. Yes.

21 Q. And I don't want to get into
22 specific numbers, but you agree that over the
23 last several years, you've gotten a bonus of
24 several thousand dollars at the end of the year

1 based on your performance as it relates to those
2 metrics that corporate would tell you about?

3 MR. MAZGAJ: Objection to form.

4 A. Yes, I have gotten a bonus, and
5 it's just something that comes in my account
6 once a year. So, yes, that is how I see my
7 bonus.

8 Q. But -- I mean, you're not
9 quibbling with the fact that it's thousands of
10 dollars, right?

11 A. I agree with you. Yes, I do get a
12 bonus every year.

13 MR. GADDY: Let's look at tab --
14 I'm sorry. I can't remember if we
15 marked that last one as an exhibit. I
16 think that would have been Exhibit
17 Number 4.

18 MR. MAZGAJ: It would have been 4,
19 yeah.

20 MR. GADDY: Okay. We'll mark that
21 one as Exhibit Number 4.

22 - - -

23 (Mooney Deposition Exhibit 5 marked.)

24 - - -

1 BY MR. GADDY:

2 Q. And then as Exhibit Number 5,

3 Ms. Mooney, I'm going to go to your tab 17.

4 It's P-HBC-1385.

5 A. Where is that at? I'm sorry.

6 Q. It's going to be back in the

7 binder.

8 A. Oh, in the binder of the -- and

9 what tab was that?

10 Q. 17.

11 A. Okay. Sorry.

12 Q. And we'll mark this as

13 Exhibit Number 5. It should say, "Giant Eagle

14 Bonus 2015 Pharmacy."

15 Let me know when you've got that.

16 A. I see it. Yes.

17 Q. And at the top under the

18 "Purpose," it says, "The pharmacy bonus program

19 is designed to encourage team members to work as

20 a team toward a common goal of improving company

21 profitability and prescription volume."

22 Do you see that?

23 A. I see that.

24 MR. MAZGAJ: If you need to review

1 the document, Emily, please do so.

2 Q. Do you see under the Roman
3 Numeral II, it talks about a pharmacy team
4 leader bonus calculation.

5 Do you see that heading?

6 A. I do, yes.

7 Q. Okay. Is it fair to say that
8 that's your role; you're a pharmacy team leader?

9 A. Yes, I'm a team leader.

10 Q. Okay. And for bonus percentages
11 underneath there and then on the right, there's
12 a minimum bonus of 1 percent, a target of
13 2 percent, and a maximum of 3 percent.

14 Do you see that?

15 A. Yes, I can see that.

16 Q. Okay. And then this policy in the
17 next section gives you the pharmacy performance
18 modifiers that are being looked at to determine
19 the size of the bonus that's given to somebody
20 in the position of pharmacy team leader.

21 Do you see that?

22 A. I do.

23 Q. Okay. And the first metric or
24 modifier that's listed there that dictates a --

1 the size of the bonus is the "Prescription Unit
2 Volume."

3 Do you see that?

4 MR. MAZGAJ: Objection to the
5 description of the document.

6 A. I see the prescription unit
7 volume, yes.

8 Q. And do you see that as a
9 pharmacist fills more prescriptions, the amount
10 of their bonus increases?

11 MR. MAZGAJ: Objection; form.

12 A. I do see that their bonus would go
13 up if they filled more prescriptions.

14 Q. Okay. And do you see that the
15 second pharmacy performance modifier that is
16 included for somebody in your role of a pharmacy
17 team leader is "Profitability"?

18 A. I see profitability listed, yes.

19 Q. And there's two different
20 measurements that are listed there. The first
21 says, "Generate a direct business line profit
22 and show a positive increase over the last
23 fiscal year."

24 Do you see that?

1 A. I see the lines, yes.

2 Q. And the next one is "Dollars per
3 prescription, goals will be specific per
4 location."

5 Do you see that?

6 A. I do.

7 Q. And so you understand that the
8 more profit, meaning the more sales, that a
9 pharmacist generates for Giant Eagle, the bigger
10 the bonus will be for that pharmacist?

11 Do you see that?

12 MR. MAZGAJ: Objection.

13 Objection; foundation. I'll leave it at
14 that.

15 A. I do. I do see that under
16 profitability.

17 Q. And one way to increase the profit
18 and increase the sale is to fill more
19 prescriptions, correct?

20 MR. MAZGAJ: Objection; form.

21 A. Yes. If you fill more
22 prescriptions, you would have more profit.

23 Q. And, therefore, the pharmacist
24 would have a bigger bonus, correct?

1 A. By this sheet, yes.

2 - - -

3 (Mooney Deposition Exhibit 6 marked.)

4 - - -

5 BY MR. GADDY:

6 Q. Okay. Let's look at tab 19 in

7 your binder. That's going to be P-HBC-1389.

8 And that last one should have been

9 Exhibit 5. So this will be Exhibit Number 6.

10 And, Ms. Mooney, do you see this

11 is the Giant Eagle 2017 bonus program?

12 Do you see that?

13 A. Yes, I see that.

14 Q. Okay. And, again, under the

15 "Purpose," it says, "The bonus program is

16 designed to encourage team members to work as a

17 team toward a common goal of improving company

18 profitability and prescription volume."

19 Did I read that correctly under

20 "Purpose"?

21 A. I see that. Yes.

22 Q. Okay. And it looks like the two

23 primary goals or metrics or modifiers for

24 determining a bonus are the same, "Prescription

1 Volume" and "Profitability."

2 Do you see that?

3 MR. MAZGAJ: Objection to form.

4 A. Yes, I'm reading that.

5 Q. Okay. And, again, with

6 "Prescription Unit Volume," the more

7 prescriptions that a pharmacist fills, the

8 bigger their bonus, correct?

9 MR. MAZGAJ: Objection;

10 foundation.

11 A. Yes. That would -- yes.

12 Q. Okay. And, again, under

13 "Profitability," do you see that the same

14 general concept applies, the more income that

15 the pharmacist generates for the business, the

16 bigger their bonus.

17 Do you see that?

18 MR. MAZGAJ: Objection;

19 foundation.

20 A. I see that. Yes.

21 Q. And it looks like here under the

22 "Measurement" section, there was an item added

23 to this one that we didn't see on the last one

24 for achieving the immunization goal that you

1 talked about a few moments ago.

2 Do you see that?

3 A. Yes. They are putting the
4 immunization goals on there. My goals are a
5 little different for doing that. I'm not --
6 more to get the immunizations out to the
7 community, but I see that on there.

8 Q. Okay. Well, regardless of how you
9 see it, the way that corporate saw it was that
10 the more -- if a pharmacist achieved their
11 immunization goal for the year, they would
12 increase the bonus that they paid to that
13 pharmacist, correct?

14 A. I see -- yes.

15 MR. MAZGAJ: Objection.

16 Objection; foundation.

17 Q. Okay. And as far as the increase
18 of -- prescription volume increasing the bonus,
19 that would include prescriptions for opiates
20 such as oxycodone or hydrocodone combination
21 products or the like, correct?

22 MR. MAZGAJ: Objection; form.

23 A. Oxycodone, opiate prescriptions
24 are a part of the prescriptions, yes, even in a

1 small amount. Yes.

2 - - -

3 (Mooney Deposition Exhibit 7 marked.)

4 - - -

5 BY MR. GADDY:

6 Q. Okay. Look at your tab number 20,

7 which is going to be P-HBC-1390.

8 So if that was Exhibit 6, this

9 should be Exhibit Number 7, please.

10 MR. MAZGAJ: Emily, how are you

11 doing? Do you need a break any time

12 soon?

13 THE WITNESS: No. What time is

14 it? Yeah, probably like ten minutes or

15 so would be good. In about ten minutes,

16 maybe, we can take a break.

17 MR. GADDY: We can do one right

18 after this document, if that's okay with

19 you?

20 THE WITNESS: Okay. That would be

21 great.

22 BY MR. GADDY:

23 Q. Okay. You see this one that we're

24 marking as Number 7 says, "Giant Eagle Bonus

1 2020."

2 Do you see that?

3 A. Yes, I see that.

4 Q. So this would have been the bonus
5 program as of last year, right?

6 A. That's what it says, yes.

7 Q. Okay. And under "Purpose," it's
8 still talking about this "common goal of
9 improving company profitability and prescription
10 volume."

11 Do you see that?

12 A. Yes, I see that.

13 Q. And, again, if you look under the
14 pharmacy performance metrics or modifiers that
15 are being looked at to determine the size of the
16 bonus, we're continuing to see increased
17 prescription fills leads to increased bonus for
18 a pharmacist, correct?

19 MR. MAZGAJ: Objection to form.

20 A. Yes. These are measurable items.
21 Yes, I see that.

22 Q. Okay. And, again, we continue to
23 see that increased profitability, meaning
24 achieving immunization goals, engaging in

1 increased auto fills. This is even talking
2 about text enrollments for customers. Hitting
3 those types of metrics will also cause an
4 increase in bonus amount for the pharmacist,
5 correct?

6 MR. MAZGAJ: Objection to form.

7 A. Yes, and also increased safety
8 with this one. So that's good.

9 MR. GADDY: Okay. That's all the
10 questions I have about this document,
11 Ms. Mooney. Did you want to go ahead
12 and take that break now?

13 THE WITNESS: Yeah, that would be
14 great.

15 MR. GADDY: Okay.

16 THE VIDEOGRAPHER: Off the record,
17 2:57 p.m.

18 (Recess taken.)

19 THE VIDEOGRAPHER: On the record,
20 3:08 p.m.

21 - - -

22 (Mooney Deposition Exhibit 8 marked.)

23 - - -

24

1 BY MR. GADDY:

2 Q. Ms. Mooney, let's please go to
3 tab 7 in your binder, which is going to be
4 P-HBC-1399. And we'll mark this as Exhibit
5 Number 8.

6 A. Okay.

7 Q. And let me know when you got
8 there.

9 A. I do. Yes.

10 Q. Okay. It looks like a Giant Eagle
11 PowerPoint presentation. Again, I don't have a
12 date on this one, but I think it's going to have
13 some screenshots of the new -- or maybe I should
14 say the current software dispensing platform
15 that you utilize. And so I just want to ask you
16 some questions about that.

17 So there is a page number at the
18 bottom right. Can you turn with me to page 98,
19 and you should have a slide that says
20 "Introduction to EPS II."

21 A. Okay.

22 Q. Do you know what EPS II is?

23 A. That's my pharmacy software
24 system.

1 Q. Okay. How long have you been
2 using EPS II?

3 MR. MAZGAJ: Objection to
4 foundation and the document.

5 A. I'm not sure. Probably 2014,
6 around about.

7 Q. Okay. If you look at the next
8 slide on the next page, it says, "EPS II
9 Overview." It says, "New software will replace
10 the current Legacy version of PDX."

11 And that was the version you used
12 before this, PDX; is that right?

13 A. Yes.

14 MR. MAZGAJ: Objection to form.

15 Q. Okay. Turn the page with me to
16 page 101 where it should say "EPS II Screens."

17 Do you see that?

18 A. Yes, I see that.

19 Q. Is that a screen you recognize?

20 A. Not -- it's not the same as my
21 screen, but similar. It's similar.

22 Q. Is there anything materially
23 different about it? I mean, any information
24 that you have on your screen that you don't see

1 here?

2 A. I don't think so. I mean, more
3 just the -- maybe just the layout of it. Yeah.
4 I mean, for the most part, it's the same order
5 entry/data entry. I don't know -- that's
6 different. I don't know what that is, but there
7 is an order entry, a will call, a data entry, so
8 it's similar.

9 Q. Okay. Let's keep going through a
10 couple of these, and let me let you comment on
11 them.

12 So the next screen on the next
13 page says, "Data Entry," if you flip the page.

14 And do you see that?

15 A. Yes.

16 Q. So I guess my first question is,
17 what we see in the bottom left-hand corner of
18 that slide, is that the old data entry version?

19 A. Yes. That was our old system.

20 Q. Okay. So this was the old PDX
21 that the EPS II replaced, right?

22 A. Yes.

23 Q. Okay. And so this -- in the top
24 right-hand section of this screen, is that your

1 current data entry screen?

2 A. Similar, yes. Pretty close.

3 Q. Okay. And so when you were
4 talking to us before about how you would enter
5 the patient name and scan in the prescription,
6 and enter the instructions from the
7 prescription, that's what we're seeing here,
8 correct?

9 A. Right.

10 Q. Okay. You told us before that you
11 had the ability to make notes about the
12 prescription that would have shown up as bullet
13 points. Where does that happen?

14 A. It would -- it's a box that would
15 be underneath where that prescription is, so
16 that's not on this screen. But it's a box that
17 would be below -- below that prescription that
18 was scanned in where it would say, "Add Image
19 Note."

20 Q. Okay. And is it a -- is it a text
21 box that you would see there on the screen, or
22 is it something you click and a text box pops
23 up?

24 A. You would see the box at the

1 bottom of the screen. It will be in yellow.

2 Q. Okay. And you click in it and you
3 can make whatever notes you want to make?

4 A. If you add the image note, that's
5 a button you would click to add. If you want to
6 view the box, anything else -- because you can
7 add multiple notes. You can click on the box to
8 view those.

9 Q. Anything else that's jumping out
10 at you about this data entry template here
11 that's different as far as what you actually use
12 now today in the store?

13 A. I mean, everything is kind of in a
14 different spot. We have more controls to
15 view -- low profile prescriber, insurance, the
16 notes box. Yeah. I mean, there's -- nothing is
17 jumping out at me. But, again, things are kind
18 of different spatially than what I'm used to,
19 so ...

20 Q. Okay. In addition to the image
21 notes that you indicated is on your screen at
22 your store, is there another notes field on this
23 screen?

24 A. There is one right on the top

1 there, on the top right. It's "Notes," so you
2 can write a note specific for that fill. You
3 can have -- check the box to write a note for
4 all fills of that prescription.

5 I believe you can -- usually those
6 are for the prescription itself. Then if you
7 click on the patient note, that will bring up
8 their notes from the profile. So there's a few
9 that you can click through there and then add to
10 if needed.

11 If I -- you can do it from this
12 screen or from the data verification screen. If
13 I had a note for counseling for the patient, I
14 would put it in that "This Fill" note and check
15 that counsel box. But those -- that's where I
16 would put the notes.

17 Q. Okay. You told us earlier, I
18 think you said, for every Schedule II
19 prescription, you check OARRS; is that right?

20 A. For every controlled prescription,
21 I check OARRS.

22 Q. Okay.

23 A. And for --

24 Q. I'm sorry. Go ahead.

1 A. Sorry. Anything that's on OARRS,
2 including Gabapentin, which isn't scheduled, I
3 check. So anything that is reported there, I
4 will check.

5 Q. Okay. Is there anywhere within
6 the software that you are -- that you are
7 required to make a note or check a box that you
8 checked OARRS or the PDMP?

9 A. Yes. We can write in those notes,
10 "verified OARRS, checked OARRS," and then put
11 our notes standard after that showing that we
12 did indeed check it.

13 Now that it's integrated into our
14 system and we -- it won't let us go to the next
15 screen until we do check the OARRS. But before
16 that, yes, we always put a note in that it was
17 verified with the time -- or the date that we
18 did and for what medication we did.

19 Q. Okay. Let me ask you a couple
20 questions about that, and let me kind of tell
21 you where I'm going here before I go there to
22 make this a little more efficient.

23 Again, you've told us throughout
24 the course of the day about some things that you

1 do that kind of seem to be maybe a little above
2 and beyond that maybe isn't required by the
3 software or the policies or procedures of
4 corporate, and so I want to make sure that I
5 understand the difference between the two. And
6 then I also want to understand this OARRS being
7 built in.

8 So let me -- let me start with
9 this: Currently there is a -- the system
10 requires you to check OARRS before filling a
11 controlled prescription; is that correct?

12 A. Yes. You can -- you have to
13 double-click on the link to OARRS. You can
14 override that, but I don't do that. I check
15 OARRS every time. So, yes, it's built into the
16 system. It makes it a little more user
17 friendly.

18 Before that, we would have to log
19 in to our own OARRS account. I would just have
20 another screen up on my computer, and as I was
21 checking the prescription, I would input the
22 information into OARRS.

23 Q. Okay. But the way the system is
24 now is in order to advance through the process

1 of filling the prescription, you must
2 double-click on the OARRS website?

3 A. Yes.

4 Q. Okay. Is there anything that you
5 have to do other than double-clicking on the
6 OARRS website in order to move forward through
7 the process?

8 MR. MAZGAJ: Object to form.

9 A. The process of checking a
10 prescription?

11 Q. Well, I'm asking do you -- is
12 there required -- does the system force you to
13 search for the name of the patient? Does the
14 system automatically populate the information
15 for the patient? What happens after you
16 double-click on OARRS in the process of filling
17 a controlled prescription?

18 A. Well, the OARRS is built into the
19 system during the data verification screen.
20 This is the data entry screen where all of that
21 information is already inputted.

22 For the pharmacist checking the
23 prescription, we would -- yes, we have to click
24 on anything that's a fault in the system. An

1 allergy would be one. OARRS is another one.
2 Any other DURs that come up that flag, we have
3 to acknowledge each one or override them before
4 we can go to the next screen.

5 So there's a lot of systems in
6 place for us to do another check on that
7 prescription, whether it be interactions or
8 duplicate therapy, allergies, all of those would
9 be in the DUR field of the data verification
10 screen.

11 Q. Okay. And I apologize, because
12 I've kind of gone off on a tangent because you
13 mentioned OARRS. So I'm not worried about this
14 screen or the document that's up on the screen
15 right now.

16 What I'm trying to make sure I
17 understand is this process that you're telling
18 me about that OARRS is built into the system.

19 So let me first ask, when did
20 OARRS become a requirement within the dispensing
21 system where you had to double-click on the
22 OARRS link in order to move forward? When did
23 that happen?

24 A. I'm not sure, really. A few years

1 ago.

2 Q. Okay. So as of approximately two
3 years ago when that became a requirement of the
4 system, when you double-click on the OARRS link,
5 what is the next thing that you see? What pops
6 up? Is it the home page for OARRS? Is it
7 something different? What do you see?

8 A. No. It is --

9 MR. MAZGAJ: Objection to form.

10 A. It brings you to that patient's
11 OARRS report.

12 Q. Got it.

13 A. Directly to it.

14 Q. Okay. And is there anywhere from
15 that report that you would ever need to navigate
16 from, or is all the information for that patient
17 displayed right there on that OARRS report?

18 A. In regards to the drugs that are
19 put into OARRS, everything is on that report for
20 that patient.

21 Q. Okay. Are there other reports
22 within OARRS that you as a pharmacist have
23 access to? For example, can you pull a report
24 on a doctor in OARRS?

1 A. No. OARRS is just the reporting
2 system for drugs that are filled. I'm not aware
3 of anything we can do with doctors.

4 Q. Okay. But when you see a report
5 for a particular patient, it will give you
6 information about what other prescriptions
7 they've had filled, correct?

8 A. Correct.

9 Q. And it will give you reports about
10 other doctors -- about the doctors that have
11 filled those prescriptions? It will give you
12 that doctor's name, correct?

13 MR. MAZGAJ: Objection to form.

14 A. Yes. It will give you the
15 doctor's information. Yes.

16 Q. So from looking at OARRS, you
17 could determine whether or not a patient has
18 been going to different doctors and getting
19 multiple prescriptions for opiates? That's the
20 type of thing that you could determine by
21 looking at a patient report in OARRS, correct?

22 A. Yes. I can see the patient -- the
23 different prescribers, the drug, the amounts,
24 the duration, what pharmacy it was filled at. I

1 have the pharmacy information if I need to call
2 them. I have the doctor information. All of
3 that is in the report.

4 Q. Okay. And I think you -- I think
5 you've answered this, but I just want to make
6 sure. If you were looking at Jane Doe's
7 prescription history and you see that she's had
8 a particular prescription filled by Dr. Smith,
9 are you able to click on Dr. Smith or run a
10 report for Dr. Smith and see all of the
11 prescriptions that Dr. Smith has had filled
12 throughout the State of Ohio?

13 A. No. I would assume that would be
14 another HIPAA issue with patient --

15 Q. I'm just worried about what your
16 capabilities are or are not.

17 A. Right.

18 Q. So you do not have the ability to
19 run a doctor report within OARRS, correct?

20 A. No.

21 Q. Okay. Kind of the same question
22 as it relates to a pharmacy. If you saw that a
23 particular patient had filled prescriptions --
24 had prescriptions filled at a particular

1 pharmacy, do you have the ability within OARRS
2 to either click on that pharmacy or run a report
3 of that pharmacy and see all of the
4 prescriptions filled by that pharmacy within
5 OARRS?

6 MR. MAZGAJ: Objection to form.

7 A. Not that I'm aware of.

8 Q. Okay. Is it fair to say that the
9 only report that you as a pharmacist have access
10 to in OARRS is a patient report?

11 A. Yes.

12 Q. Okay. Can we look at the next
13 slide. It's going to be page 103, and it says
14 "DUR Check." And on this slide, are we seeing
15 the same thing where bottom left is the old
16 system, top right is the new -- new format?

17 A. Yes. The DUR screen in the new
18 system has changed a lot from this. But
19 generally, yes, the script would be listed on
20 the left and the DURs would be listed like that
21 in red on the right.

22 Q. Okay. So let me just ask you
23 generally, what is a DUR?

24 A. A drug utilization review. So

1 it's going to look at things like that where
2 it's a therapeutic duplication, an allergy,
3 someone filling too much, too little,
4 overutilization, underutilization, drug
5 interactions, things like that.

6 Q. Let me ask you this, at what point
7 in the process do you see the DURs?

8 MR. MAZGAJ: Objection; asked and
9 answered.

10 A. It's on the second screen after I
11 verify the prescription.

12 Q. Okay. And what you see when the
13 DURs are alerted or for a pop or flag, is
14 something we see similar to what we see on this
15 slide where you see them in a different color
16 with a notification for you, correct?

17 A. Yes.

18 Q. Okay. And the ones that we see
19 here look like they're colored red. Are they
20 all colored red, or is there a color coding
21 system?

22 A. No. There's some yellow. If
23 there's like a -- that aren't really related so
24 much to -- it might be like a different NDC or a

1 different manufacturer was used last time than
2 to this time. That's not technically a DUR. It
3 just points out a difference or -- it just
4 points out a change, but it doesn't mean that
5 it's something that needs to be addressed as
6 much as the red ones would. We have to override
7 those. There's a button on there that you click
8 through those. You have to override each one of
9 those showing that you looked at each one.

10 MR. GADDY: Okay. Mike, do you
11 mind blowing up that screen on the
12 right.

13 BY MR. GADDY:

14 Q. Okay. So there's some that are
15 red, some that are yellow. Any other colors for
16 DURs?

17 A. I don't think so.

18 Q. Okay. Do any of the DURs have a
19 requirement where you must do some type of entry
20 or make some type of entry in order for it to be
21 cleared and continue through the process?

22 A. Giant Eagle has a standard in --
23 where we do have to write some response to these
24 things. So for this, for example -- well, this

1 one is not great.

2 Okay. So one of the
3 therapeutics -- say that therapeutic duplication
4 with the Simvastatin was a 10-milligram tablet
5 filled on 4/2 of '08 and this prescription now
6 is for the 20-milligram tablet. We have to
7 override these, so we hit that button, or we can
8 enter through them as well.

9 When we -- once we've done that,
10 the "complete" button in the corner lights up
11 where we can put in our biometrics, and then a
12 box pops up to where we have to put in our
13 documentation.

14 We also can put in our
15 documentation to do this -- the fill notes,
16 which is what I typically do so that there's a
17 note in both places. So in this case, if it
18 were a 10-milligram to a 20-milligram, I could
19 say as a counsel note -- and there's a button
20 usually on this screen as well to counsel. It's
21 not on this picture.

22 But as I'm checking it, I would
23 look at the patient's profile, see that the
24 10-milligram tablet is deactivated in their

1 profile. And then I'll make a note in this box
2 here, "Dose increase from 10-milligram to
3 20-milligram." And then my -- I deactivate the
4 10-milligram in the profile. And I can -- I
5 usually say that as well just in case it was a
6 mistake so it could be looked at if the patient
7 doesn't know of a change.

8 But we -- I hit the counsel
9 button. I write that note in the box in the
10 bottom left-hand corner. And then when I put my
11 biometrics in for complete, another box shows
12 up, and I put the same note -- I usually just
13 copy and paste it also into that box so that
14 it's a record in both places, in the counsel and
15 then on that fill note as well.

16 So, yes, there's documentation.
17 And Giant Eagle expects us to write some sort of
18 documentation. Writing "okay" or "approved" is
19 not acceptable. So they want to see what
20 your -- what you are seeing on the screen and
21 your thought process in approving a
22 prescription, so ...

23 Q. Okay. Let me just ask, is that
24 note process -- is that required by the

1 dispensing software in order to move through the
2 process?

3 A. You do have to put --

4 MR. MAZGAJ: Objection; form.

5 A. You don't have to put anything
6 here, but to get through the screen, you have to
7 write something.

8 Q. Okay.

9 A. But Giant Eagle makes sure that we
10 are writing our thoughts on why that medication
11 is going through. And then that's where I would
12 put my counsel notes as well, so ...

13 Q. Okay. So the software requires
14 some type of note to be entered, and you're
15 telling me that Giant Eagle has a policy that it
16 has to be a good, thorough note; is that fair?

17 A. Yes.

18 Q. Okay. Okay. Can you tell me
19 what -- the different types of DURs that could
20 pop or alert for opiate-related prescriptions.

21 A. Well, usually it is like
22 over/underuse. If -- we can see when the
23 patient filled it last. It will show up just
24 like how this is on this screen with the

1 Simvastatin. It will show up the last fill or
2 as a therapeutic duplication as well. It can be
3 on a couple screens.

4 There's also some dosing in there
5 where it will flag to check dosing. If it's a
6 high dose, sometimes -- the computer takes the
7 quantity and the day's supply and calculates a
8 dose kind of in the background. So it's
9 something to go off of.

10 For pediatric patients in
11 particular, all of their dosing is based on
12 weight. So that's another thing that will flag,
13 is high dose in pediatrics.

14 I'm trying to think. Those are
15 the few I can think of.

16 Q. Okay. I understand the pediatric
17 issues. So let me ask you about dosing for
18 adults.

19 What is the trigger or what is the
20 criteria that would make a dosing DUR alert for
21 an opiate-related script?

22 A. Well, it wouldn't so much trigger
23 a high dose. I mean, opiates, you -- some
24 people can take large doses.

1 If they're a cancer patient that
2 are on, you know, long-term treatment and
3 breakthrough pain meds, they can be on very high
4 doses of these meds. So there's really no
5 maximum dose, per se.

6 But, I mean, in my checking
7 process, I do look at those dosings. You see
8 that the scripts -- their last script shows up,
9 is it consistent with their last prescription
10 dosing, things like that.

11 Q. And, again, I appreciate you
12 telling me your personal practices, which is
13 fine, but I'm really just trying to understand
14 the system and how the dispensing system works.

15 So I'm going to ask you a couple
16 questions about the pediatrics in just a second,
17 but what I hear you telling me about adults is
18 there would not be a DUR that would flag for
19 dosing as it relates to an opiate prescription
20 for adults, that there's no maximum trigger
21 amount that's going to make that alert show. Is
22 that correct?

23 A. I don't --

24 MR. MAZGAJ: I'm going to object.

1 Wait. Wait. Emily, just a second.

2 I'm going to object to -- Emily is
3 only here as a fact witness. She can
4 only speak to her own facts. So she
5 hasn't been designated as a
6 representative of the company. So she
7 can answer your questions based off of
8 her personal experience.

9 So the instruction is improper.

10 With that, Emily, you can answer
11 the question again.

12 A. I don't know that. I believe
13 there's something there, but I'm not completely
14 sure. There are max dosing DURs, but I'm not
15 sure on that.

16 Q. Do you recall ever seeing a dosing
17 DUR for an adult with an opiate prescription?

18 A. Like -- I mean, I did -- those
19 DURs show up with the dosing that the patient
20 has been on before. So that's how you -- that's
21 how I would interpret that. Most opiates don't
22 have a high dose or max dose listed with them,
23 but if there was a max dose on a drug, it would
24 be in the DUR system.

1 Q. Do you recall ever seeing a max
2 dose on an opiate prescription for an adult?

3 MR. MAZGAJ: Objection to form.

4 A. I don't. I don't know offhand.

5 Q. You indicated that you may see
6 DURs for opiate prescriptions for a pediatric,
7 correct?

8 A. No. I -- I said I see a lot of
9 max dosing for pediatric patients.

10 Q. Okay. Were you talking about
11 opiates when you said that?

12 A. No.

13 Q. Okay.

14 A. I -- I'm just saying in general we
15 see that a lot for pediatric patients when we're
16 discussing the DURs.

17 Q. Okay.

18 A. Max dosing for pediatric patients,
19 that flags a lot because it's weight-based
20 dosing.

21 Q. Okay. Well, I'm asking you
22 specifically about opiate prescriptions.

23 Is there any particular DUR for
24 opiate prescriptions related to dosing that you

1 would see for a pediatric patient?

2 MR. MAZGAJ: Objection to form.

3 A. Again, I'm not sure -- I mean, I'm
4 sure -- like I said before, a lot of opiates
5 don't have max dosing. I don't -- I don't know.

6 Q. Are there ever any DURs -- I think
7 you told us -- you told us over and
8 underutilization. You referenced dosing, but
9 we've covered that.

10 Any other DURs that you recall
11 seeing for opiate prescriptions?

12 A. I think I told you those two. The
13 therapeutic duplication, over and
14 underutilization. Those are usually those DURs
15 that I see.

16 Q. Any others that you can think of?

17 A. Not that I can think of offhand.

18 Q. Okay. What type of scenario is
19 going to make a therapeutic duplication DUR
20 trigger for an opiate prescription?

21 A. If they've had another
22 prescription filled in that same class, so
23 another opiate filled.

24 Q. Okay. Do they have to be

1 currently --

2 A. They also flag other controlled
3 meds as well.

4 Q. Do they have to be currently on
5 that other medication in order for it to flag,
6 or if they've had a prescription filled several
7 months ago for a 30-day supply, would it still
8 flag?

9 A. It would still flag. It doesn't
10 have to be right away.

11 Q. Okay. So in that scenario, the
12 explanation may be they've exhausted their
13 medication from six months ago, this is a new
14 prescription for a new event and, therefore,
15 there is no duplication.

16 Is that -- do I have that
17 generally right?

18 A. Correct.

19 MR. MAZGAJ: Objection to form.

20 A. If there's a therapeutic
21 duplication from months ago, then, yes, I would
22 override that DUR and make that statement in my
23 note.

24 Q. Okay. How far back could you see

1 a therapeutic duplication DUR for opiates? I
2 mean, if they had a script filled at Giant Eagle
3 four years earlier for an opiate, are you still
4 going to see that duplication DUR?

5 MR. MAZGAJ: Objection to form.

6 A. Giant Eagle's system keeps three
7 years of records in the system at a time, so I
8 wouldn't -- I would assume that there is nothing
9 from four years back, that it wouldn't be a
10 duplication at that point. The medication would
11 have been expired, so ...

12 Q. Okay. What period of time are you
13 going to see a duplication? One year, eighteen
14 months, two years?

15 A. I don't know that information.

16 Q. Okay. Under what scenario would
17 you see an underutilization DUR related to an
18 opiate prescription?

19 A. If the patient got a prescription
20 months ago, would have been out of it in a
21 month, those would flag for an underutilization.
22 If the patient was on the same dose or given the
23 same dose and I saw that it wasn't filled for
24 months, that would trigger me to make a call to

1 the doctor because that patient probably would
2 be treatment naive, again, at that point and
3 might not be okay at the same dose as what they
4 were given and were on. So that would be an
5 underutilization DUR.

6 Q. I'm not following you. Can you
7 give me a real life example of how that happens?

8 A. Sure. Say a patient was on
9 morphine 15 milligrams, twice a day, so a
10 long-acting opiate. Patients that are on
11 morphine are usually titrated there by taking a
12 short-acting prescription first, an oxycodone or
13 a hydrocodone or something like that, to treat a
14 severe pain.

15 Patients are usually transferred
16 over to a long-acting opiate, mostly cancer
17 patients or something like that, that need it
18 for the long term.

19 So if I saw a patient on morphine
20 15 milligrams, twice a day, and the patient was
21 getting it consistently month to month, no
22 issues, long-term therapy, and then it stops,
23 and they weren't getting it for three months.
24 And then they come in with a new prescription

1 for morphine 15 milligrams, twice a day. That's
2 concerning to me because if this patient was off
3 of those medications -- that medication three
4 months and then started at that morphine dose,
5 it could be dangerous. So I would call the
6 doctor.

7 Here, you know, the patient was in
8 the hospital or in rehab for three months and so
9 they weren't getting their prescriptions filled
10 with us, as long as I had that documented, I
11 know that that patient is still on that dose and
12 I can dispense it to them.

13 If they weren't on that, then they
14 would have to be restarted as a treatment naive
15 patient given, you know, an oxycodone
16 prescription short-acting and tapered to that
17 dose.

18 Q. Okay. Thanks. That was helpful.

19 So is that scenario that you just
20 ran through one in which you may get a DUR for
21 underutilization if after a three-month gap a
22 prescription for 15-milligram morphine was
23 brought in?

24 A. Right. That would be an

1 underutilization DUR.

2 Q. Okay. And the last one that you
3 told me you may see for an opiate prescription
4 was overutilization.

5 Can you give me an example or
6 explain to me the context in which you would see
7 an overutilization DUR?

8 A. Sure.

9 MR. MAZGAJ: Objection to form.

10 A. Those --

11 MR. MAZGAJ: Opioid specific,
12 Jeff? Sorry. You didn't say opioid.
13 Do you want opioid?

14 MR. GADDY: Yes. Thanks, Matt.

15 BY MR. GADDY:

16 Q. Opiate related, please.

17 A. Okay. In that case, yes, it would
18 come up as a DUR. This happens a lot to -- not
19 so much at my store because we fill
20 prescriptions a day early, but sometimes it
21 comes up where they -- a DUR shows this patient
22 has accumulated so and so tablets over the last
23 whatever time period, and it will show that in
24 the DUR.

1 So it's just another flag for me
2 to check the profile and see when they filled
3 those or to look at the OARRS report and make
4 sure that it makes sense.

5 So that DUR comes up, but it's not
6 usually -- it's usually in relation to the
7 therapeutic duplication in a way because that
8 patient has been on that for a long time. So
9 they add up the tablets that they might have
10 extra over those months.

11 Q. Okay. So the example that you're
12 thinking of when you would see an
13 overutilization would be if somebody came in
14 several days early to have their prescription
15 filled, correct?

16 A. Right.

17 Q. Okay. Did we cover all of the
18 ones that I think you said you would commonly
19 see or expect to see for opiate-related
20 prescriptions?

21 A. The ones that I can recall.

22 Q. Okay. Do you ever check for any
23 DURs that don't alert there on the screen?

24 MR. MAZGAJ: Objection to form.

1 A. I don't -- I mean, the DURs will
2 flash on the screen. I mean, like, are you
3 asking if I do any extra checks?

4 Q. Right. I'm just asking if there's
5 any drug utilization reviews that you perform
6 outside of the ones that alert on the screen. I
7 know you've told us a lot today about the
8 process that you personally go through. I was
9 wondering if there was anything else that came
10 to mind.

11 A. Right. No, I don't believe so. I
12 mean, I check the profile. I check through the
13 DURs, the OARRS. That's usually the review
14 that's done with the drugs. So, no, I don't --
15 I can't think of anything else.

16 Q. Okay. Is there ever a DUR for
17 drug-to-drug interaction that you may expect to
18 see for an opiate-related prescription?

19 A. I mean, so the one that comes to
20 me would be patients on Percocet or Norco, which
21 is hydrocodone and acetaminophen or oxycodone
22 and acetaminophen combo in one pill.

23 We would get, like, a flag, like,
24 an -- I mean, we could get a flag, like, on the

1 Tylenol, if they're on another medication that
2 contains Tylenol, if they're on a -- or if they
3 have an allergy to Tylenol or an allergy to one
4 of the components in the med.

5 I mean, that's another one, I
6 guess, too. Patients say they're allergic to
7 codeine but they're getting a Percocet
8 prescription, so we verify if there really is a
9 true allergy or if they've had the Percocet
10 before. That's another one.

11 I'm trying to think. I mean, I
12 think it's mostly just with the Tylenol products
13 on it, not with the drugs.

14 Q. Are you familiar with the term
15 "cocktail" as it relates to are prescription
16 drugs specifically involving an opiate?

17 A. Yes. I'm familiar with the --
18 yes, the opiate with the benzodiazepine and the
19 Soma prescription.

20 Is that what you're saying, if it
21 flags with that?

22 Q. I'm kind of changing topics. I'm
23 asking --

24 A. It would relate to that too, but

1 it would put all the controlled meds in the DUR
2 flag.

3 But, yes, I am familiar with that.

4 I'm sorry.

5 Q. Okay. So what is the
6 significance, from your perspective, of a
7 cocktail prescription, that combination of an
8 opiate, a benzo, and a muscle relaxer?

9 A. Well, I mean, it is something that
10 would stand out to me, mostly the Soma as that
11 third part of the cocktail. When looking at a
12 patient, you have to individualize the patient
13 and what they're being treated for.

14 I have a lot of patients that
15 have -- have chronic pain, but then also have
16 anxiety, are being treated by a psychiatrist,
17 and require a benzodiazepine for anxiety.

18 So those two together -- while
19 that is something that flags to me, those two
20 together can -- when you look at the profile,
21 when you look at the patient, when you look at
22 the OARRS report and see what doctors are
23 prescribing those, that isn't so much of an
24 issue.

1 But adding that Soma in -- like I
2 said earlier today, any time that Soma is
3 prescribed, I call the doctor right away. There
4 is very little evidence that Soma helps a pain
5 patient and can only increase the risk of abuse
6 and dependency on those meds.

7 So when I see that -- and over the
8 years, I don't see it as much because I've
9 called so many doctors, they are probably sick
10 of me preaching to me. So I don't really see
11 that so much anymore, because I think I've
12 done -- and my partners at Giant Eagle have
13 really done our due diligence there to make a
14 difference in how they're treating pain
15 patients. I don't -- I don't see it so much.
16 And when I do, we usually don't dispense the
17 Soma portion of the script.

18 Q. Okay. Let me see if I can kind of
19 unpack everything you said there.

20 So I think you said that you
21 recognize an opiate -- a prescription for an
22 opiate, a benzodiazepine, and a muscle relaxer
23 to be what is referred to as a cocktail,
24 correct?

1 A. Yes.

2 Q. Okay. And I think you indicated
3 that you do have some patients that you believe,
4 based on all the circumstances, may
5 appropriately be on a dual combination of an
6 opiate and a benzodiazepine; is that fair?

7 A. Yes.

8 Q. Okay. And I think what I heard
9 you to say, that what troubled you the most is
10 the addition of the Soma or the muscle relaxer,
11 correct?

12 A. Right.

13 MR. MAZGAJ: Objection; misstates
14 the testimony.

15 Q. Okay. Do you agree that just the
16 prescription for the opiate with the
17 benzodiazepine is a flag that you need to look
18 at and investigate further?

19 MR. MAZGAJ: Objection to form.

20 A. Those two prescriptions, yes. If
21 received together, and any time a patient is on
22 both, I do look at those both to make sure I'm
23 not missing anything. I do another check.

24 Q. Okay. If you saw a prescription

1 come in for an opiate plus a Soma, you will
2 agree that's also a flag that you would look at
3 and do further investigation before deciding to
4 fill that dual combination, correct?

5 MR. MAZGAJ: Objection to form.

6 A. Yes. I call the doctor every time
7 I receive a Soma prescription.

8 Q. Okay. And would you agree that if
9 you saw a prescription for Soma in combination
10 with an opiate, that would increase the level of
11 concern you have?

12 MR. MAZGAJ: Objection --

13 A. Absolutely.

14 MR. MAZGAJ: -- misstates
15 testimony.

16 Q. Let me see if I can understand a
17 little bit about the spacing or the potential
18 time between these different prescriptions being
19 presented that would cause you to have this
20 concern.

21 Because obviously not all
22 prescriptions may be presented at the same time;
23 is that fair?

24 MR. MAZGAJ: Objection to form.

1 A. Right.

2 Q. So, for example, if an opiate
3 prescription was presented on day one, and if on
4 day eight, you know, one week later, the same
5 patient came in and presented a prescription for
6 a benzodiazepine, would that pique your
7 interest, would that flag to you, as something
8 that you need to look at? Now you have a
9 patient with an opiate prescription, let's say
10 it was a 30-day prescription, and now they're
11 having a second prescription presented for
12 benzodiazepine.

13 So even though they weren't
14 presented at the same time, is that still going
15 to be something that flags or piques your
16 interest for you to look into further?

17 MR. MAZGAJ: Objection to form.

18 A. Yes. So any time that that's
19 presented, I mean, we would see that on the DUR
20 screen, and I would look into that further.
21 Yes.

22 Q. Okay. How many days apart do
23 these prescriptions have to be in order for it
24 to be something for you to look into?

1 So you just said a week apart
2 you're going to look into them. Are you going
3 to look into them if it's two weeks apart? Is
4 it if the medications are overlapping in the
5 time that they would be on them? Is that the
6 trigger?

7 Can you help me understand that?

8 MR. MAZGAJ: Objection to form.

9 A. Anytime those drugs are taken by
10 the same patient, they are looked at relative to
11 the entire patient. So anytime that
12 prescription is presented, I -- with the DURs,
13 that would flag to me to do another check to see
14 which doctor -- or is the same doctor
15 prescribing this? What kind of doctor is this?
16 What -- why are they getting this?

17 Yes, so that's what I look for
18 through the DUR review and on the patient
19 profile. So anytime those are dropped off in
20 any relative time, those would flag to me.

21 Q. Gotcha. So would it be fair to
22 say that if there was ever overlapping
23 prescriptions -- whether it's one week, two
24 weeks, 30 days, whatever, whether there's

1 overlapping prescriptions for an opiate and a
2 Soma, for example, that's going to be the type
3 of thing that's going to pique your interest and
4 cause you to do further investigation, correct?

5 MR. MAZGAJ: Objection to form.

6 A. Right. Those would cause me to do
7 more evaluation.

8 Q. Okay. So those -- seeing the
9 duplicate prescription for an opiate and a Soma
10 over -- you know, at the same period of time,
11 whether it's one week, two weeks or 30 days,
12 that's going to be a red flag for you to
13 evaluate further, correct?

14 MR. MAZGAJ: Objection to form.

15 A. Yes, I would do another check
16 on -- an extra check to see what prescriber is
17 doing -- or what the prescriber is doing, make a
18 call, document why the patient would be on
19 those. Yes.

20 Q. Okay. And same thing when we're
21 talking about an opiate and a benzodiazepine, as
22 long as there's overlapping therapy there,
23 whether it's a week apart that they're
24 presented, two weeks apart, or 30 days apart, if

1 there's an overlapping therapy for an opiate and
2 a benzodiazepine, again, that's going to be a
3 red flag for you that's going to cause you to do
4 additional research, correct?

5 MR. MAZGAJ: Objection to form.

6 A. Yes, I would do additional
7 research anytime those drugs showed up in the
8 system. I mean, even if it was more than a
9 month out. Anxiety meds, you know, they might
10 not be taking it daily, but they still have
11 those in their possession to where if they take
12 something as needed, it would be important to
13 know, even in the last six months to a year,
14 that these medications are being given, because
15 if a patient gets an intermittent prescription,
16 has surgery, gets a pain medication, and the
17 doctor didn't let them know that the two
18 medications interact and can cause harm when
19 used together, that's what I do as part of my
20 practice, is to make sure that that patient
21 knows that those two shouldn't be taken
22 together. That's another -- another example.

23 Q. So even seeing those two drugs
24 prescribed as far apart as six months or year,

1 you're still going to see that as a potential --
2 as a flag and as something that you're going to
3 look into further and make sure you do your due
4 diligence on? Is that a fair encapsulation of
5 what you said?

6 A. I would --

7 MR. MAZGAJ: Objection to form.

8 A. I would do my due diligence. That
9 is part of my due diligence, yes, especially for
10 a benzodiazepine, that it is important to go
11 that far back, so yes.

12 Q. I think I heard you say that you
13 may have some DURs that would alert if you had
14 these cocktail drugs presented; is that correct?

15 A. Yes. I think any controlled med
16 will flag. They don't really know what it is,
17 like, labeled as. I don't know -- I don't know
18 if it shows up as a certain -- under a certain
19 heading like the therapeutic duplication, but
20 anytime -- those drugs all show up in my DUR. I
21 mean, I don't know what they're under and what
22 heading or if they're yellow or red. But they
23 do show up in the DUR and then also in the
24 profile, so ...

1 Q. Okay. Well, let me stick with the
2 DUR for now, and I want to make sure I
3 understand what you're saying.

4 So if a patient presents a
5 prescription for a benzodiazepine and you're
6 going through your verification process and you
7 get to the DUR screen, and that patient, say,
8 three months earlier had a prescription for an
9 opiate for about a 30-day supply, would you --
10 are you telling me that you would see a DUR
11 there that tells you that there was the earlier
12 opiate prescription?

13 MR. MAZGAJ: Objection to form.

14 A. Yes. It's -- something is in
15 there showing that drug. I don't know what it's
16 titled, what the link is, but it might even just
17 be the fact that it was a controlled medication
18 and it flags. But, yes, it is in the DUR.

19 Q. Okay. Same question. If a
20 patient presents a Soma prescription and you're
21 going through the verification page, are you
22 going to get an alert in the DUR process that
23 there was a prior script for an opiate?

24 A. I'm not sure about that. I don't

1 know. I don't fill a lot of Soma anymore. Like
2 I said, usually I can talk prescribers out of
3 it. So I don't -- I don't know about that one.

4 Q. Is the reverse true where if you
5 have a prescription presented for an opiate and
6 the prescribing history includes a
7 benzodiazepine or a Soma, that you're going to
8 see an alert that those drugs have been
9 previously prescribed when you get to the DUR
10 section?

11 MR. MAZGAJ: Objection to form.

12 A. Definitely the controlled meds.
13 Again, I'm not sure on the Soma.

14 MR. MAZGAJ: Emily, we've been
15 going another hour. Are you okay?

16 THE WITNESS: I can take a break,
17 five minutes or so.

18 MR. GADDY: Okay. Sounds good.

19 THE VIDEOGRAPHER: Off the record,
20 4:05 p.m.

21 (Recess taken.)

22 THE VIDEOGRAPHER: On the record,
23 4:13 p.m.

24

1 BY MR. GADDY:

2 Q. Ms. Mooney, we talked a little bit
3 about red flags a few minutes ago. Can you tell
4 me what your definition is of a red flag in the
5 context of filling an opiate prescription.

6 MR. MAZGAJ: Objection to form.

7 A. Well, I mean, a red flag is
8 anything that would, in my judgment as a
9 pharmacist and my due diligence as a pharmacist,
10 come up as strange or something that needs to be
11 looked into with regarding opiate or controlled
12 prescriptions in general.

13 Q. Would you agree that when you see
14 a red flag under that definition to you, that
15 that means you should stop and investigate
16 further?

17 MR. MAZGAJ: Objection to form.

18 A. Yes. I think I mentioned a lot of
19 times how many things I stop at to make the best
20 decision when it comes to filling prescriptions.

21 Q. Sure. No, you're exactly right,
22 and I don't know that we always put the term
23 "red flag" on it when you were talking about
24 those things, but you'll agree that those types

1 of things that would make you kind of press
2 pause and go into a little bit more
3 investigation, those are red flags in this
4 context, correct?

5 MR. MAZGAJ: Objection to form.

6 A. I don't know what -- I mean, I do
7 extra checks on -- but, I mean, a red flag, does
8 that just mean I stop? Then, yes, there are
9 things that cause me to stop when reviewing a
10 prescription.

11 Q. Can you give me a list, just kind
12 of like a bullet point list, of potential red
13 flags that you may be looking out for when it
14 comes to making a decision about filling an
15 opiate prescription?

16 A. Sure.

17 MR. MAZGAJ: Objection to form.

18 A. Sure. I -- let's see. If it's a
19 doctor I'm not aware of, if it's a new patient
20 that I haven't -- that we haven't filled for
21 before, a drug that isn't commonly prescribed
22 for pain, high doses or quantities of that drug,
23 multiple doctors. I think that's a few that I
24 can think of right away. Different dosing.

1 Q. What do you mean by "different
2 dosing"?

3 A. Just the dose of -- or directions
4 that look strange or supplies from -- a
5 short-term supply and then following by another
6 prescription right after, duplicate
7 prescriptions. I think that's about it, that I
8 can think of.

9 Q. Okay. I wrote down a doctor
10 you're not familiar with, a new patient that
11 you're not familiar with, a new drug that's not
12 commonly prescribed for pain, high dosages or
13 high quantities of a drug, multiple doctors
14 prescribing a drug and different dosings.

15 Anything else that you can think
16 of that you're kind of on the lookout for as far
17 as red flags for determining whether or not to
18 fill an opiate prescription?

19 MR. MAZGAJ: Object to form.

20 A. Not -- obviously the combos that
21 we were talking about earlier, that would be one
22 too. I think that's a pretty good list.

23 Q. When you say "combos," you're
24 talking about the opiate with the benzo, the

1 opiate with the Soma, or all three together?

2 A. Right. A combo of a few of the
3 meds, yes.

4 Q. Okay. And do you agree that
5 identifying and evaluating these types of red
6 flags in looking at an opiate prescription is a
7 critical part of the corresponding
8 responsibility that you have as a pharmacist?

9 A. It is my corresponding
10 responsibility. I do that with every
11 prescription that I check, so yes.

12 Q. And you agree that's something
13 that you have to do as a pharmacist as part of
14 your corresponding responsibility, right?

15 A. Right. That is my job as a
16 pharmacist, to make sure that I get the
17 prescription, the right prescription to the
18 patient safely. So that is my responsibility.

19 Q. Okay. And do you agree that all
20 red flags that you identify for a particular
21 prescription need to be resolved to your
22 satisfaction prior to you making the decision to
23 fill that particular prescription?

24 A. Yes, that is my decision, and I'm

1 thankful that my company supports my decision in
2 that.

3 Q. And is it within -- let me ask it
4 this way: Do you agree that the steps or the
5 information that you learned during the
6 investigation of any red flags should be
7 documented?

8 MR. MAZGAJ: Objection to form.

9 A. Yeah, I do document. Like I was
10 saying earlier when I went through the DURs, any
11 DUR that I check, I have to make a note as to
12 why I'm okay with that and proceed forward, so
13 yes.

14 Q. Okay. So I think -- the question
15 I asked is, if you agree that any information
16 you learned during your investigations of red
17 flags should be documented, and your answer is,
18 "Yes, they should be documented," right?

19 A. Yes, I document --

20 Q. Right.

21 A. -- any --

22 Q. Well, I think, yes, you agree they
23 should be documented, and then the step further
24 is, yes, you actually do document, correct?

1 A. Yes, I document. Yes.

2 Q. Okay. If there was -- if we were
3 to take a particular prescription that you made
4 a decision to fill and we were looking for --
5 let's just say this particular prescription
6 presented numerous red flags, and you
7 investigated each of those red flags, resolved
8 those red flags, and determined that this was
9 appropriate to fill, where would be the best
10 place to look within the documentations that
11 you've done to see the documentation that led to
12 your resolving those flags and filling the
13 prescription?

14 Does that make sense?

15 MR. MAZGAJ: Objection to form.

16 A. Yes, that makes sense.

17 Well, they would be in a few
18 areas. It would just depend on what -- what I
19 was investigating. So if it was an issue with
20 the dosing, the doctor, the directions,
21 something like that, I would be calling the
22 doctor, and that documentation would be put in
23 the image note on the prescription.

24 If I was looking into patients,

1 I'd document that I checked the OARRS. If --
2 any separate note or any counseling notes would
3 be documented in the notes field on that
4 prescription. So there's --

5 Q. That's --

6 A. -- quite a few places. Sorry.

7 Q. Sorry. I didn't mean to interrupt
8 you.

9 You said -- first you said the
10 image notes, which I'm with you there. That's
11 the bullet points under the prescription scanned
12 in, right?

13 A. Right.

14 Q. Okay. And then you said -- I
15 thought you just said the next one would be
16 notes on the prescription.

17 Is that the same thing, or is that
18 somewhere different?

19 A. Well, the first one I said would
20 be an image note on the prescription, so that --
21 if you printed the prescription, those notes
22 would -- from the scan, you would see those
23 notes --

24 Q. Okay.

1 A. -- underneath the script.

2 So that's the image note. And
3 that would be dealing with the mechanics of the
4 prescription, if it was a clarification on the
5 actual script itself.

6 Q. Okay. And then you said the --

7 MR. MAZGAJ: Emily, do you need to
8 finish that prior question? You were
9 cut off, and I just want to make sure
10 you had a chance to finish your answer.

11 A. Oh. No, that's okay. I'm okay.

12 Q. Okay. So notes regarding the
13 prescription, you said if you looked into the
14 doctor, you called the doctor, that stuff would
15 be on the image notes.

16 Then you said that you may look
17 into the patient, check OARRS, those notes would
18 be where?

19 A. Those should be on the -- "this
20 fill" and note field for that prescription.
21 It's called a "this fill" note.

22 Q. Can you spell that? "This fill,"
23 t-h-i-s?

24 A. Uh-huh.

1 Q. Okay.

2 A. Yes.

3 Q. Is that on the patient profile, or
4 where is that?

5 A. It's attached to the prescription.
6 And, yes, in the patient profile. So all those
7 are retrievable in the profile.

8 Q. Okay. But that's different than
9 the image notes?

10 A. It is.

11 Q. Okay. And you've already told us
12 about the DUR notes, right?

13 A. Yes.

14 Q. And that's a third place, right?

15 A. It is.

16 Q. Okay. Is there a fourth or a
17 fifth or a sixth place that we may find your
18 documentation about clearing red flags for any
19 one particular prescription?

20 A. So, I mean, there's call notes
21 too. So if the prescription was ever in our
22 call queue, there's notes in the calls on those
23 prescriptions, but then those -- the resolution
24 would be on the image note on the prescription.

1 And then there's patient notes as well, just
2 general notes. There's a tab in the profile
3 that can be used.

4 Q. Okay. So the call note, you might
5 have a -- you might put a call in the queue to
6 call a doctor and ask him a question, and you
7 might make some notes there. But what you're
8 telling me is the resolution of the issue that
9 you were calling about would actually be in the
10 image notes, so that would be the better place
11 to look?

12 A. Right.

13 Q. Okay. And then as far -- what are
14 we going to find in the patient notes that we
15 wouldn't find in the image notes, the this fill
16 notes or the DUR notes?

17 A. Those would be just general notes
18 in regard to the patient. Like I was saying
19 earlier with two strengths of levothyroxine, the
20 thyroid medication, that's what they're
21 maintained on. We could write a note in their
22 general patient note that the patient is on both
23 doses so that it's easier, you know, checking
24 their prescriptions, we're not constantly

1 counseling them on the same thing every month,
2 so to avoid duplication in our counseling.

3 Q. Okay. You've told us about some
4 things that are available through the software
5 to help you through this decision-making process
6 in investigation of red flags as far as OARRS
7 or, you know, notes that you can see on the
8 prescription or whatnot.

9 I want to ask whether or not there
10 are any reports that you have access to through
11 Giant Eagle that you ever utilized to help you
12 make the decision about whether or not you can
13 resolve certain red flags that may appear.

14 MR. MAZGAJ: Objection to form.

15 A. I'm not aware of any reports in
16 general.

17 Q. Is it ever your practice to pull
18 any reports from the dispensing system to help
19 you in your decision about whether or not to
20 fill an opiate prescription?

21 MR. MAZGAJ: Objection to form.

22 A. No, I don't have any reports. I
23 don't -- I don't have any or use any.

24 Q. Okay. Have you -- has it ever

1 been your practice to request from either your
2 PDL or further up the chain in corporate reports
3 or information that could help you make a
4 decision about filling a particular
5 prescription?

6 MR. MAZGAJ: Objection to form.

7 A. No.

8 Q. Is that something that would even
9 occur to you to do, to ask your PDL or corporate
10 to run a chain-wide report on a doctor or
11 something similar to that?

12 A. No. I mean, I take each
13 prescription as it is individually to the
14 patient. So, I mean, I take each on its own.
15 So I don't -- I don't know if those -- I don't
16 see myself having a need for a report like that.

17 Q. Okay. I've had the opportunity to
18 talk with several of the other folks at Giant
19 Eagle, some of the corporate level folks about
20 some of the programs they have place, not only
21 for dispensing and pharmacy-related issues,
22 but --

23 A. You're cutting -- I can't hear
24 anything right now. I don't know why.

1 (Discussion held off the record.)

2 Q. I've had the opportunity to talk
3 to them not only about some of the pharmacy or
4 dispensing issues, but also issues related to
5 distribution.

6 So one of the things that I've
7 learned -- and I'll just make this
8 representation to you -- is that there is a
9 corporate level threshold report that they use
10 at the corporate level to look at the amount of
11 drugs that are being distributed from the Giant
12 Eagle related distribution centers to the
13 pharmacies.

14 So let me just first ask you, are
15 you familiar with that threshold-based report?

16 MR. MAZGAJ: Objection to the
17 testimony of counsel and the
18 representation.

19 A. I'm not familiar with that.

20 Q. Okay. During the course of your
21 work as a pharmacy manager, has anybody ever
22 talked to you about the threshold for any
23 controlled substance that relates to your
24 particular store?

1 MR. MAZGAJ: Objection to form.

2 A. I think I remember -- I think I
3 remember an ordering issue at one point that may
4 have had to do with that, a threshold or some
5 sort, but I really wasn't involved in it. So I
6 don't -- I think it was -- like, the corporate
7 end handled it, but that's the extent of it.

8 Q. Okay. Outside of that one
9 issue --

10 A. No. I'm sorry. Go ahead.

11 Q. Okay. Outside of that one issue,
12 you're not aware of anybody communicating with
13 you about your store's threshold or giving you
14 guidance on where you are as it relates to the
15 threshold or anything like that?

16 MR. MAZGAJ: Objection;
17 foundation.

18 A. No.

19 MR. MAZGAJ: Assumes facts not in
20 evidence.

21 A. No, nothing like that.

22 Q. Have you ever had the occasion to
23 run reports on the number of prescriptions that
24 you've filled? Have you ever had the need to do

1 that?

2 MR. MAZGAJ: Objection; asked and
3 answered.

4 A. No.

5 Q. What about inventory reports? Is
6 that ever something that you would have the need
7 to run in helping you make a determination about
8 whether or not to fill a prescription?

9 MR. MAZGAJ: Objection to form.

10 A. I don't really see the correlation
11 between my inventory and deciding to fill
12 something. I run inventory reports for audits
13 and for inventory purposes, but I don't for that
14 reason.

15 Q. I'm with you. I don't either.
16 I'm just making sure.

17 Have you ever had the occasion to
18 run a doctor report within your store in trying
19 to determine -- to make a decision about whether
20 or not to fill an opiate prescription?

21 MR. MAZGAJ: Objection to form.

22 A. No. I don't -- I've never used a
23 doctor report.

24 Q. What do you recall about that time

1 that there was communication to you regarding a
2 threshold issue? What do you remember about
3 that?

4 MR. MAZGAJ: Objection to form.

5 A. I told you what I remembered. I
6 remember a mention when ordering, but I don't
7 recall anything else.

8 Q. You mentioned earlier the COVID-19
9 pandemic, I think, as it revolved around
10 immunizations and things like that.

11 Do you also have an understanding
12 that the country is in the midst of an opioid
13 epidemic?

14 MR. MAZGAJ: Objection to form.

15 A. I've heard of the term. I mean,
16 in publications, but I don't -- I don't know the
17 difference between a pandemic and an epidemic,
18 so I don't -- I don't really know what that
19 means, per se. I do know there's a problem with
20 opiates and that people can abuse them if
21 that's -- but that's as far as my knowledge goes
22 there.

23 Q. Okay. What do you mean when you
24 say that there's a problem with opiates and that

1 people can abuse them?

2 A. I mean, I think that it's known,
3 thus the "epidemic." I don't know exactly what
4 it means, but that there are people that do
5 abuse opioids. That's why we have all of these
6 safeguards in place and checks as pharmacists to
7 make sure that we're not contributing to any
8 abuse.

9 And I know myself, I do my due
10 diligence, and I know that I -- me and my
11 company, we aren't contributing to that. So I
12 feel -- I feel good as a person knowing that I
13 don't contribute to that.

14 Q. Have you ever seen evidence of
15 the -- what you call the problem of people
16 abusing opiates in your community?

17 A. Yes. Yes, I have.

18 Q. Okay. In what form?

19 A. My father, for one, was addicted
20 to painkillers. So I saw it firsthand, what
21 that can do.

22 Q. Okay. In what other forms have
23 you seen it?

24 And I'm sorry about that.

1 A. No, that's okay.

2 That's my firsthand experience
3 when it comes to opioid abuse. So that's the
4 only one that I know of.

5 Q. Okay. Are you aware that it's an
6 issue -- the problem, as you put it, with opioid
7 abuse within the State of Ohio?

8 MR. MAZGAJ: Objection to form;
9 calls for expert testimony.

10 A. Again, I only know my firsthand
11 experience. I know that it was easy for him to
12 get that, but I don't know anything else.

13 Q. Have you seen any evidence of drug
14 abuse or drug-seeking behavior at your stores?

15 MR. MAZGAJ: Objection to form;
16 vague.

17 A. I mean, I have refused to fill
18 prescriptions in the past if I'm not comfortable
19 filling them. That's my choice as a pharmacist.
20 I'm supported by that with my company.

21 So I feel confident in my ability
22 to determine if those prescriptions are okay to
23 fill, that they're valid and used for the right
24 purposes. So I have no problem telling someone

1 no, but the majority of my patients are getting
2 their meds appropriately and using them
3 appropriately.

4 MR. GADDY: I'm going to move to
5 strike that as nonresponsive.

6 Q. My question is, have you seen
7 evidence of drug abuse or drug-seeking behavior
8 within your store?

9 I think you told us earlier you've
10 had instances where you've had people call in to
11 your store and pose as a doctor's office and try
12 to call in an opiate prescription.

13 Is that fair?

14 MR. MAZGAJ: Objection to form,
15 compound; asked and answered.

16 You can provide an answer, Emily.

17 A. I mean, yes, that is something
18 that has happened, but it -- I mean, it
19 wasn't -- I was thinking you meant like a C-II
20 prescription where there -- I mean, yes, I have
21 refused to fill something that someone has come
22 in with a prescription for until I've talked to
23 the doctor.

24 That happens a lot where someone

1 can come in on the weekend and want a script
2 filled when they know I'll need to talk to a
3 doctor first and I refuse to fill it.

4 So, I mean, if that's considered a
5 seeker, in your term, I have refused to fill
6 medications for that reason.

7 Q. And you've also seen evidence
8 within your store of people trying to
9 impersonate doctors' offices in order to have
10 you fill prescriptions for opiates.

11 Is that fair?

12 MR. MAZGAJ: Objection; form.

13 A. I mean, the called-in prescription
14 was for a Gabapentin prescription, and then
15 for -- so, I mean, you can't call in an -- like
16 the C-II opiates. You can't call in a
17 prescription for that. So that's where I'm
18 getting tied up, I think.

19 You can call in a prescription for
20 a C-III through V prescriptions; tramadol,
21 benzodiazepines, things like that. So, yes, in
22 that case, I've had that happened where they've
23 called in prescriptions for those drugs and I've
24 caught that.

1 Q. Have you either seen or become
2 aware of robbery attempts at Giant Eagle
3 pharmacies where the pharmacy was the target of
4 a robbery and specifically pills were the target
5 of the robbery?

6 A. No.

7 Q. Have you interacted with any
8 customers at your pharmacy that you suspected to
9 be addicted to opiates?

10 MR. MAZGAJ: Objection to form.

11 A. That's a hard question because
12 addiction and dependency -- I mean, I have a lot
13 of patients that are dependent on opiates.
14 You're going to become dependent on opiates.

15 I think addiction seems more along
16 the lines of abuse, and I don't -- I don't know
17 anyone that has abused it of my patients that
18 I've dispensed to.

19 Q. Have you seen or become aware of
20 drug paraphernalia, such as needles, on Giant
21 Eagle property?

22 A. Yes, that, I have seen sometime --
23 one instance, one of the store managers saw one
24 in the bathroom and then another in the parking

1 lot.

2 Q. Have you --

3 A. I think two issues there.

4 Q. Have you seen or suspected that
5 you ever saw a drug deal on Giant Eagle
6 property?

7 MR. MAZGAJ: Objection to form.

8 A. I have not --

9 MR. MAZGAJ: Vague.

10 A. -- seen a drug deal.

11 Q. Have you seen or become aware of
12 individuals overdosing and receiving treatment
13 on Giant Eagle property?

14 A. I am aware of one -- one time I
15 believe someone overdosed in the parking lot,
16 and that was only one instance.

17 Q. Do you know if they had to
18 administer Naloxone to that person?

19 MR. MAZGAJ: Objection.

20 A. I am not sure. I don't know.

21 Q. Have you ever suspected that one
22 of your patients or somebody seeking a
23 prescription from you might be intending to sell
24 their pills?

1 A. No. If that were the case, I
2 wouldn't dispense the medication to them. I've
3 never been aware of anything like that.

4 Q. Well, and I'm making the
5 assumption that you wouldn't have dispensed the
6 medication. But my question is if you ever came
7 to that conclusion and, therefore, did not
8 dispense the medication?

9 A. Right. No, I've never had that
10 happen.

11 Q. Okay. Have you ever had any
12 contact with law enforcement regarding an
13 opiate-related issue at your store?

14 A. Yeah, I -- I mean, I used to -- I
15 mean, years ago especially, but I -- Lake County
16 Narcotics is right down the street. If I
17 suspect anything that I think warrants a call, I
18 just give them a call. I have all their
19 information, their business cards. So they're
20 pretty easy to talk to.

21 Q. About how many times have you had
22 to call the Lake County Narcotics office
23 regarding opiate-related issues at your store?

24 A. It's been a long time now. I

1 mean, probably four or five times -- I don't --
2 that I'm remembering that I've called them and
3 given them information to look into a patient.

4 Q. Has there ever been a time in your
5 job as a pharmacist revolving around an
6 opiate-related prescription that you've been
7 scared at work or after work?

8 MR. MAZGAJ: Objection to form.

9 A. I mean, I've been yelled at a few
10 times. I've had experience with patients when
11 it comes to those prescriptions. They don't
12 usually make much of a fuss, I guess. Usually
13 they know there's rules in place, that we put in
14 place.

15 If something is too early or if I
16 need to get ahold of a doctor, they're usually
17 pretty understanding when it comes to something
18 like that. Or if it's an issue, the ones that
19 are no good, if I present an issue, they usually
20 just walk away, so ...

21 Q. Okay. What do you mean when you
22 say you've been yelled at and had experience
23 with those patients? What's the context for
24 that?

1 A. Well, I work in a grocery store
2 and deal with customers and co-pays and
3 insurance. So a lot of patients aren't happy to
4 come to the pharmacy to have to pay for those
5 things. So, I mean, day to day there's usually
6 some unhappy customers when it comes to the
7 pharmacy and their prescriptions.

8 Q. And to the extent I didn't say
9 this earlier, I'm asking specifically in the
10 context of opiate-related prescriptions.

11 So is there any time in the
12 context of an opiate-related prescription,
13 whether it's, you know, not filling a
14 prescription for a customer or worried about
15 what a customer is going to do with the
16 prescription, or whatever, that it's kind of
17 caused you to be uncomfortable or scared in your
18 role as a pharmacist?

19 MR. MAZGAJ: Objection to form.

20 A. No, I don't -- I can't recall
21 anything that I've been nervous about. Like I
22 said, most patients are -- they might not be
23 happy about it, but they're understanding. If
24 there's some follow up that I need to do or if

1 they're not getting their prescription on time,
2 I -- they know they have to wait for it, so ...

3 MR. GADDY: I think I'm getting
4 pretty close to the end. If it's okay,
5 why don't we take about five minutes,
6 and I think I've got two or three quick
7 topics left, if that's okay with
8 everybody.

9 MR. MAZGAJ: Sounds good.

10 THE VIDEOGRAPHER: Off the record,
11 4:48 p.m.

12 (Recess taken.)

13 THE VIDEOGRAPHER: On the record,
14 4:57 p.m.

15 BY MR. GADDY:

16 Q. I've seen some stuff in some of
17 the documents, Ms. Mooney, about a controlled
18 drug record box that is kept in every store.

19 Do you know what I'm talking about
20 there?

21 A. I do, yes.

22 Q. What is that?

23 A. It is our record year to year. We
24 get a new box every year that has our dispensing

1 guideline in it. It has month-to-month
2 recording of orders, C-II prescription orders,
3 and then other controlled meds also
4 month-to-month, but separated.

5 There's also our inventory -- our
6 monthly audits, our yearly inventory, any
7 outdate returns. That's what I can think of
8 right now.

9 Q. Okay. When you say C-II
10 prescription orders, do you mean where you order
11 drugs from the distribution center?

12 A. Yes. Through our CSOS, we can
13 order -- those -- our 222s from. Those are all
14 filed by month.

15 Q. Okay. I was just making sure you
16 weren't talking about prescriptions, hard copy
17 prescriptions.

18 A. No. I'm sorry. Just the drug
19 ordering.

20 Q. Okay. Where are the
21 prescriptions, the hard copy prescriptions? Are
22 they filed somewhere in the store?

23 MR. MAZGAJ: Objection. It's
24 duplicative of 30(b)(6) testimony.

1 A. Yes, those are kept in the store.
2 They're filed in packs of 100, maybe even more
3 now since we get more e-scripts than hard
4 copies, and then those files are kept in boxes
5 and then kept for ten years.

6 Q. Okay. Do you print out a hard
7 copy of an e-script and file it also, or just
8 the hard copies that are hand brought into the
9 store?

10 A. We used to, but I believe -- I
11 don't know when, but the State of Ohio changed
12 that to where we don't have to print any longer.

13 Q. Okay. Where are those hard copy
14 scripts within your store? And what I'm -- I'm
15 just trying to get at whether or not they're --
16 where you would have to go to get them.

17 A. Right. The most recent
18 prescriptions are kept in the pharmacy. We have
19 drawers that store them in case we need them in
20 a recent time, but our storage is upstairs above
21 the store in a locked room. I'm the only one
22 that has a key to that.

23 Q. Okay. Approximately what time
24 period is going to be there in the pharmacy in

1 the drawers; the last week, the last month, the
2 last year?

3 A. For a C-II prescription, probably
4 quite a few months. Yeah, I mean, I would say
5 definitely six months' worth in the pharmacy.

6 Q. Okay. Is there anything that
7 you -- do you ever have a need to go into the
8 controlled drug record box?

9 A. I do it most days, because with
10 ordering, I check in those orders and then file
11 the 222 and the order sheets in that box. So I
12 use that box daily.

13 Q. Okay. Do you use the box for
14 anything other than ordering?

15 A. Like I said, my monthly audits are
16 filed there. I do -- we have a perpetual
17 inventory of our C-IIIs, but then also do monthly
18 audits. So those are all filed there, and then
19 our yearly inventory as well.

20 Q. Okay. Other than the drug orders
21 and those things you just told me about, any
22 other reason that you go into that box?

23 A. Oh, not that I can think of right
24 now.

1 Q. Okay. You told me that your
2 controlled substance dispensing guidelines are
3 in that box. We've also spent several hours
4 today with you kind of telling me about all the
5 different hoops that you jump through for
6 different steps in the process.

7 Do you ever, during the course of
8 your work, pull out those dispensing guidelines
9 and use them to help you make a decision about
10 whether or not to fill an opiate prescription?

11 MR. MAZGAJ: Objection to form.

12 A. I use my own judgment, my
13 professional judgment, to fill the
14 prescriptions. I know that I am -- I know what
15 Giant Eagle's guidelines are. We share the same
16 views there as to how to fill a prescription.
17 So I don't need to use those guidelines because
18 I already use them in my practice.

19 Q. Okay. So the answer to the
20 question is, no, you don't ever pull out the
21 controlled substance dispensing guidelines and
22 flip through them and use them to help you make
23 a decision about whether or not to fill an
24 opiate prescription, fair?

1 A. Right.

2 - - -

3 (Mooney Deposition Exhibit 9 marked.)

4 - - -

5 BY MR. GADDY:

6 Q. Those guidelines are tab number 2

7 in your binder. It's going to P-HBC-28.

8 MR. GADDY: I forget what number

9 we're on. I think this is number 9,

10 Exhibit Number 9.

11 BY MR. GADDY:

12 Q. Do you see -- do you have those

13 guidelines in front of you?

14 A. Yes. "Controlled Substance

15 Dispensing Guidelines," yes.

16 Q. Do you know whether or not there's

17 ever any updates to these guidelines if they get

18 reissued every year under your box?

19 A. I'm not aware of any updates.

20 Q. Okay. At the top of the page, it

21 says, "Purpose." It says, "To provide

22 guidelines for the proper dispensing of

23 controlled substances that support the

24 corresponding responsibility mandate placed upon

1 pharmacists to exercise due diligence in the
2 decision to fill or not to fill a controlled
3 substance prescription."

4 Do you see that?

5 A. Yes, I do.

6 Q. Okay. And that's -- we've talked
7 today about some of the things that you do when
8 exercising due diligence, right?

9 A. Right.

10 Q. If you turn to about two-thirds of
11 the way down the second page, you'll see a
12 section that says, "Appropriateness of
13 Controlled Substance Prescriptions," and then in
14 parentheses it says, "Red Flags."

15 Do you see that?

16 A. Yes, I do.

17 Q. Okay. And some of these specific
18 red flags you've mentioned and talked about
19 already, and some of them maybe haven't been
20 discussed. And so I just want to ask you a
21 couple questions about some of them and whether
22 or not they're the types of things that you look
23 at, and if so, how.

24 So the first one that we see there

1 under number 1 is the combo prescription that we
2 spent some time talking about.

3 Do you see that?

4 A. Yes.

5 Q. And you've already talked to us
6 about how that -- how those different
7 combinations of those drugs are something that
8 you look at, and you told us about the tools
9 that you use to look for those, correct?

10 A. I did, yes.

11 Q. Okay. The second one says, "Lack
12 of individualization of dosing."

13 Do you see that?

14 A. Yes.

15 Q. Okay. Do you understand what's
16 being communicated there?

17 A. I see that as each -- I mean, I
18 check as an individualized person. Each person
19 is an individual.

20 So you're saying what? I don't --
21 I mean, are you saying that the -- so I'm just
22 reading this. The act of individualized dosing,
23 is that -- yes, you would want to start at the
24 lowest effective dose and go up from there.

1 So I think we talked about that
2 before, too, with patient dosing and how when
3 I'm checking a prescription, I'm making sure
4 that they're not getting morphine without first
5 being started on a lower dose, immediate release
6 breakthrough pain dose, of like oxycodone or
7 hydrocodone. So, yes, that is what I look for.

8 Q. Okay. Would you agree that it
9 would be a red flag if you had a particular
10 doctor who for every patient that they saw, they
11 wrote them the exact same prescription for the
12 exact same drug for the exact same length of
13 time for the exact same dosage, that the drug --
14 the prescriptions that he or she was writing
15 were not individualized to the patient?

16 Do you agree that that would be a
17 red flag and something that you would want to
18 look at and examine further?

19 MR. MAZGAJ: Objection to form.

20 A. So there's a lot of doctors in the
21 area, particularly pain clinics and pain
22 doctors, that do choose to prescribe certain
23 drugs. I think that they're familiar with them,
24 that it gives them the best outcomes.

1 So while, yes, I see how that
2 would be something I would look into, but I look
3 into any opiate prescription -- since that's
4 what we're talking about, I look into that
5 anyway, but I don't see that as a reason not to
6 fill, because I take other things into account.

7 Like I said, there's a lot of good
8 pain management doctors that do stick to a few
9 drugs that they're comfortable with, and I don't
10 see anything wrong with that. But it's based on
11 the individual. So, I mean, I don't -- I'm
12 looking at it as a picture for the patient. So
13 I don't -- I don't know if that would be
14 something I would see to just not fill a
15 prescription for someone.

16 Q. Okay. So the question I asked was
17 whether if you had a particular doctor that was
18 writing the same script for the same dose for
19 the same length of time for every patient that
20 he or she saw, would that be something you'd
21 want to look into further. And I think I
22 understood you to say, yes, it's something you
23 would want to look into further, but it may not
24 be determinative.

1 Is that fair?

2 A. Right. I would definitely look
3 into that further, as I do any time, and then --
4 yes, but that would not be a reason to not give
5 the prescription to the patient on its own.

6 Q. Okay. What would be the way that
7 you would discover that a doctor was writing the
8 same prescription for the same drug for the same
9 length of time for the same dosage unit to every
10 patient that he saw?

11 How would you become aware of that
12 information?

13 MR. MAZGAJ: Objection to form.

14 A. I mean, I'm familiar with a lot of
15 the doctors in the area that I dispense
16 prescriptions for. But like I said, I mean,
17 it's an individualized dose. I mean, each
18 person has to be taken on its own. So it's -- I
19 see what this is, but on its own, it doesn't
20 represent the big picture for that patient.

21 Q. But my question is a little bit
22 different.

23 I'm asking how you would become
24 aware that a doctor is writing the same script

1 for the same drug for the same length of time
2 for the same dose for every patient?

3 And I think the first thing you
4 said is you're familiar with the doctors. Other
5 than being familiar with the doctors, is there
6 any other way that you would become aware of
7 that?

8 MR. MAZGAJ: Objection to form.

9 A. I mean -- yeah, I mean, if I get
10 prescriptions from that doctor, multiple, then I
11 can see a trend.

12 Q. Okay. So it would be spotting a
13 trend based on receiving multiple prescriptions
14 from the same doctor and noticing that they were
15 all the same?

16 A. Right.

17 Q. Okay. If you turn the page, at
18 the top there's requests for early refills. I
19 think we've talked about that.

20 The next one is one I don't think
21 we've talked about today. It says, "Further
22 than expected distances of the patient or
23 medical provider from the pharmacy."

24 Do you see that?

1 A. I do, yes.

2 Q. Is that a particular red flag that
3 you look for in determining whether or not to
4 fill an opiate prescription?

5 MR. MAZGAJ: Objection to form.

6 A. Again, yes, that is something I
7 would look at, in taking in each prescription as
8 an individual prescription. Our location where
9 my store is located, it's -- and I've called on
10 a lot of these to double-check and to clarify.

11 But what I see most of the time --
12 we have a pretty large rural area, about 45
13 minutes -- anywhere between 25 and an hour away
14 from the store, but the clinics -- where they
15 don't really have doctors' offices or any
16 specialties. So patients traveling to see their
17 doctor from those areas are not -- not a huge
18 concern for me in most respects.

19 Yes, in some -- that's always
20 something in the back of my head. But when I
21 see where the patient lives versus where they're
22 coming to get treatment, I see why they would
23 come to our pharmacy. That's not something,
24 again, that I would not fill a prescription for

1 them after looking into.

2 Q. Is there a particular distance
3 that you would say, "Okay. This is a flag to
4 me. I need to figure out why their doctor is so
5 far away or why the patient lives so far away"?

6 Is there any particular distance?
7 Is it being in a different county, being out of
8 state, anything like that that you say, "All
9 right. This is now a flag that I need to
10 investigate"?

11 MR. MAZGAJ: Objection to form.

12 A. I mean, any prescription that's
13 out of state, I am definitely making a call to
14 the prescriber. I don't really get a whole lot
15 of those anymore. I mean, I remember years ago,
16 we would get some from out of state. Again, I
17 would call, make sure the prescription was a
18 valid document as necessary.

19 But -- I mean, usually -- usually
20 I don't have a whole lot of those. Maybe the
21 west side is probably the farthest distance, the
22 west side of Cleveland. So that's probably
23 about maybe an hour away.

24 I don't really have too many past

1 that that I remember.

2 Q. Okay. So anything within that
3 distance is not really going to pique your
4 interest as being an outlier or anything
5 unusual. Is that fair?

6 A. No, not necessarily. I mean, I
7 take all of that into consideration, especially
8 if it's with -- as a new patient to the pharmacy
9 or a doctor I'm not aware of. So one of these
10 in combo with another.

11 I mean, it doesn't mean that I
12 don't look at that. I do. But I am very
13 familiar with the area. I've lived here all my
14 life. So I do -- I do know a little more about
15 that.

16 Q. Okay. Let's look at the next on
17 the list. It says -- number 6 says,
18 "Overwhelming percentage of the pharmacy
19 business is devoted to filling controlled
20 substances."

21 Do you see that?

22 A. Oh, yes.

23 Q. Are you -- are you tracking within
24 the store on a daily basis what percentage of

1 your prescription fills are controlled versus
2 non-controlled and weighing that percentage into
3 whether or not you fill any particular opiate
4 prescription?

5 MR. MAZGAJ: Objection to form.

6 A. No, I don't track that. I
7 don't -- I don't track that. But I don't think
8 an overwhelming percentage of my business is
9 devoted to that. So I don't think that's
10 something I have to worry about.

11 Q. Do you know how this factor,
12 number 6, would be used to make a decision on an
13 individual prescription for an individual
14 patient regarding an opiate script?

15 MR. MAZGAJ: Objection to form.

16 A. I could imagine that patients
17 would go to a place that would fill their
18 prescriptions without any checks on why or if
19 it's correct. And, again, that's just me
20 imagining, because I don't do any of those
21 things, so ...

22 Q. Right. But this is a Giant Eagle
23 policy --

24 A. Right.

1 Q. -- distributed to Giant Eagle
2 stores.

3 I can't figure out how this factor
4 is helpful. And maybe I'm missing something.

5 But I'm saying if you as a
6 pharmacist can explain to me how number 6 would
7 help any pharmacist make a decision about
8 whether or not to fill or not fill any
9 individual opiate prescription.

10 Can you tell me how it would help?

11 MR. MAZGAJ: Objection; lack of
12 foundation.

13 A. I don't -- I don't know. I mean,
14 my -- my business is not devoted --
15 overwhelmingly devoted to filling controlled
16 substances. So I just don't see that as
17 something that would pertain to me. So I don't
18 know.

19 Q. Do you know any Giant Eagles that
20 do fall into that category?

21 A. I do not.

22 Q. Okay. Number 7 says, "Failure to
23 contact and/or follow up with other pharmacists
24 for not filling prescriptions from the

1 particular provider in question."

2 Do you see that?

3 A. Yes.

4 Q. Okay. So let me -- let me ask you
5 kind of a question about that.

6 Do you have anywhere within the
7 dispensing platform where there's any
8 documentation that other pharmacies would not be
9 filling prescriptions for any particular
10 prescriber?

11 A. I think we've said earlier -- I
12 mean, there's nothing that's been put out that
13 we don't fill a prescription for a particular
14 provider. I've never -- and I've never had that
15 come from anyone at Giant Eagle.

16 I will say that if there's
17 anything that comes up at a store -- I don't
18 know -- a suspicious prescription or something
19 like that, that's when we would use e-mail to
20 contact our group in the area or region to where
21 they'll mention something like that.

22 Every once in a while our --
23 Rick Shaheen, who is in charge of, you know, the
24 loss prevention -- and he will send out

1 something, but it's not -- we won't not fill a
2 prescription for a prescriber.

3 Q. Have you ever asked up the chain
4 to your PDL or to corporate and asked that any
5 particular prescriber be blocked and made the
6 case that you shouldn't fill any
7 prescriptions -- and obviously I'm talking about
8 opiates -- for a particular prescriber?

9 Have you ever done that?

10 A. No, I have not.

11 Q. Are you aware of anybody at Giant
12 Eagle at the pharmacy level that has done that?

13 A. No, I'm not.

14 Q. Okay. So number 7 seems to be
15 talking about talking to other pharmacists who
16 won't fill prescriptions from a provider, and it
17 sounds like, from what you're telling me, that
18 doesn't really apply at Giant Eagle. Is that
19 fair?

20 A. No, I'm not saying that. I mean,
21 this is based on -- for the pharmacist. I mean,
22 this is a guideline for the pharmacist. So I
23 mean, like I'm saying, it's individualized to
24 the patient and also with the pharmacist. And I

1 think at the end of this document -- I mean,
2 Giant Eagle supports us in whatever we decide to
3 do as a pharmacist. So --

4 Q. I hear you. My question is about
5 number 7. It says, "Failure to follow up with
6 pharmacists who don't fill prescriptions from a
7 provider" -- I assume that means the health care
8 provider in question.

9 And what I thought I heard you
10 tell me is that Giant Eagle doesn't have a
11 blanket refusal-to-fill-type program where you
12 don't refuse prescriptions from particular
13 providers.

14 A. Right.

15 Q. Okay.

16 MR. MAZGAJ: Objection to form.

17 Q. So if you don't have a program
18 where you have a blanket refusal to fill for
19 providers, then help me understand how a
20 pharmacist is going to use number 7 when filling
21 a prescription at Giant Eagle and trying to make
22 a decision about whether or not to fill an
23 opiate prescription.

24 A. Well, it says "other pharmacists."

1 So I interpret that -- I mean, a pharmacist
2 could choose not to fill a prescription.

3 Q. Okay. That's a fair
4 clarification.

5 Have you ever made the decision
6 not to fill prescriptions from a certain health
7 care provider?

8 A. No, I have not.

9 Q. Okay. Are you aware of any
10 pharmacist at Giant Eagle that has ever made the
11 decision to not fill prescriptions from any
12 certain physician or health care provider?

13 A. No, I'm not.

14 Q. Number 8 says, "Filling
15 prescriptions for patients who arrive in
16 groups."

17 Is that something that you look at
18 in making your determination about whether or
19 not to fill an opiate prescription?

20 A. I haven't experienced that one
21 myself in regards to prescriptions. So, no, I
22 haven't -- I don't know of that. But, yes, that
23 would look very suspicious.

24 Q. Okay. Number 9 says, "Cash

1 transactions on controlled substances."

2 Again, I don't think that's
3 something we mentioned. Is that something that
4 would pique your interest?

5 A. Years ago, yes, where patients
6 wouldn't want to use their insurance. Now a lot
7 of -- a lot of patients don't have insurance,
8 and they use discount cards for their
9 prescriptions.

10 So that is a little, I think,
11 outdated in relevance to practice right now,
12 especially now too with the -- with OARRS being
13 so readily available, it kind of shows us now if
14 there's going to be a double billing to a cash
15 and then to an insurance.

16 So that one, I think, was more
17 relevant years ago than it is now.

18 Q. Okay. And then the last one on
19 here says, "Verification that a prescription is
20 legitimate is not satisfied simply because the
21 provider performed blood tests and MRIs on the
22 patient."

23 Do you see that?

24 A. Yes.

1 Q. Okay. Again, is there -- how does
2 that help a pharmacist make a determination
3 about whether or not to fill an opiate
4 prescription?

5 A. I think this is more that -- just
6 showing that the patient is an established
7 patient, which would make sense. I don't have
8 any other real comment on that one.

9 - - -

10 (Mooney Deposition Exhibit 10 marked.)

11 - - -

12 BY MR. GADDY:

13 Q. Okay. Let's look at tab 21, which
14 is going to be P-HBC-5017. We'll mark it as
15 Exhibit Number 10.

16 Let me know when you've got that.

17 MR. MAZGAJ: Is there anything she
18 should focus on first?

19 MR. GADDY: We'll look at the
20 cover, and then I'll tell her where to
21 go.

22 A. Okay.

23 Q. Do you see at the top of the page
24 it's an e-mail from Chris Miller from back in

1 December of 2016, and the subject is "Weekly
2 Notes."

3 Do you see that?

4 A. Okay. Yes.

5 Q. There's going to be several
6 attachments, and some of them are related to
7 some of these metrics issues that we've been
8 discussing before. What I want to do is just
9 show you one of those pages and ask you if
10 you've ever seen it before or anything like
11 that.

12 So I'm going to turn -- I think
13 the easiest way to find it is the Bates number
14 at the bottom right-hand corner ends in 9210.

15 MR. MAZGAJ: Objection to the
16 document as being outside the Track 3
17 jurisdictions and foundation.

18 Q. Are you with me, Ms. Mooney?

19 A. Yeah. I don't even know what the
20 store is, so I -- what store is this?

21 Q. Let me just ask you some general
22 questions, and maybe we can move on pretty
23 quickly.

24 Do you see at the top of this it

1 says, "Customer Satisfaction Scorecard"?

2 A. Yes.

3 Q. Okay. And I think you told us
4 earlier that, you know, because you work for a
5 business and they have customers, that one of
6 the things that the company focuses on is
7 improving customer satisfaction. Is that fair?

8 A. Yes.

9 Q. Okay. And I think you told us
10 that one of the things you have an understanding
11 that the company does from time to time is
12 conduct surveys, voice-of-customer-type feedback
13 processes in order to get input from the
14 customers on where the company is doing good and
15 where the company has room to improve.

16 Is that fair?

17 MR. MAZGAJ: Objection; misstates
18 the testimony.

19 A. Yes.

20 Q. Okay. And this one -- again, this
21 is just a template. I didn't pick this one for
22 any particular reason. I think it's the first
23 one in a list of a bunch, if you flip through
24 the next couple of pages.

1 But do you see at the top left, it
2 says "Giant Eagle Pharmacy." Then it says,
3 "Customer Satisfaction Scorecard." It looks
4 like this is for a store in Chippewa. And the
5 very top entry says, "Retail index, current
6 three periods."

7 Do you see that?

8 A. Uh-huh.

9 Q. And then for this particular one,
10 the second entry down says, "Where should I
11 focus?" And then there are two entries there,
12 one for "Speed and Ease of Checkout" and the
13 second says "Time to Fill from Order."

14 Do you see that?

15 MR. MAZGAJ: Objection;
16 foundation. You haven't even
17 established that she's seen this.

18 A. Yeah, I mean, this isn't my store,
19 and I don't -- I don't know where this is from
20 exactly, so ...

21 Q. Have you ever seen a customer
22 satisfaction scorecard like this from your
23 store?

24 A. I don't recall one. I mean, this

1 is probably quite a few years old. So I
2 don't -- I don't even remember what's on these.
3 I mean, I can read this from this, but, I mean,
4 I don't -- I don't even remember this.

5 Q. Okay. Do you ever get feedback
6 from anybody regarding your store's performance
7 on the customer satisfaction surveys?

8 A. So our metric, I guess, is just
9 the amount of surveys that we receive, and then
10 we are scored on that. But I don't -- I
11 don't -- every once in a while I see a
12 breakdown, but it's not -- I don't know. I
13 mean, it's not -- it's not broken down like
14 this. So I don't really -- I mean, I don't
15 really know what is on those -- on those
16 surveys.

17 Q. Okay. So I understand that one of
18 the things the company wants you to do is have
19 people fill out surveys, right?

20 A. Right.

21 MR. MAZGAJ: Objection to form.

22 Q. Okay. And what I'm asking is
23 whether or not there's anybody, whether it's
24 your PDL, whether it's somebody else from

1 corporate, whether it's anybody, who ever comes
2 and says, "Okay. Regardless of how many surveys
3 were filled out, here's the results of the
4 survey. Here's the areas we did really well in.
5 Here's the areas that we need to focus on as we
6 move through the survey process."

7 Does that process ever happen?

8 A. It doesn't. I mean, I get sent --
9 I think I get sent something when it comes to
10 the surveys. I don't even -- I don't know what
11 it is that they look at. I just -- I mean, we
12 don't have this.

13 Q. Okay. Let's look at tab
14 number 16, which is going to be P-HBC-37.

15 A. Okay.

16 MR. GADDY: We'll mark this as
17 Exhibit 11, I think.

18 - - -

19 (Mooney Deposition Exhibit 11 marked.)

20 - - -

21 BY MR. GADDY:

22 Q. Let me know when you're there,
23 Ms. Mooney.

24 A. Yeah. I have the tab up.

1 Q. Okay. I want to look at a couple
2 of these other metric reports and just see if
3 it's the type of thing that you're familiar
4 with.

5 Let's look at page -- it looks
6 like this one actually does have page numbers.
7 So I'm on page 32.

8 And about a quarter of the way
9 down the page, there's an entry for store 6377
10 in Painesville, which is I think where you told
11 us you work, correct?

12 A. Okay. Yes.

13 MR. MAZGAJ: Objection to
14 foundation of the document.

15 Q. Do you see that?

16 A. Yes, I do.

17 Q. Okay. And it has some numbers
18 there, the P9 to P11 is 80 percent, something is
19 0 percent, so on and so forth. And then it
20 talks about areas to focus on. And the first
21 area noted is "Pharmacy Team Member
22 Professionalism," and the next is "Time to Fill
23 from Order."

24 Do you see that?

1 MR. MAZGAJ: Objection. The
2 document speaks for itself.

3 A. Yes, I see that.

4 Q. Okay. And are these types of
5 reports or scores for your store the type of
6 thing that you've ever seen before?

7 A. I can tell you I see my retail
8 index score. I will focus on complaints in
9 regards to team member interactions, but that's
10 how I take these surveys.

11 So, I mean, I don't -- I don't
12 know -- I mean, I don't know where you're going
13 with this. But, yes, I look at those scores.
14 But the only thing that is important to me with
15 these is that I address customer complaints.

16 So if I have a customer complaint
17 in the pharmacy team member professionalism, I
18 will address that with the customer and then
19 with my team member.

20 So that's how I take these
21 customer service scores. I just take them at
22 face value, but I address each patient.

23 Q. Okay. But you are provided with
24 your retail index scores and the areas to focus

1 on and those types of things, correct?

2 A. I mean, this report says it. I'm
3 familiar with my score. The areas for focus, I
4 don't -- I don't -- I don't really see those or
5 maybe really don't address those so much, as
6 much as individualized customer complaints.

7 So if those come to me, which come
8 to me in a different -- by a different avenue,
9 those are important for me to address.

10 My score here -- I mean, it's --
11 the score is fine. So I don't think I need to
12 look any further than that, and I don't.

13 Q. Okay. I'm not asking what you do
14 with the scores. I'm not asking what you think
15 is important or not important about the scores.

16 I'm just asking whether or not you
17 were told about your scores in the different
18 areas of this Rx retail index report.

19 A. I am sent my scores. I don't look
20 at -- there's no areas for focus sent to me that
21 I'm aware of.

22 Q. Okay. But you're aware of how you
23 scored in the different areas related to
24 complaints or time to fill an order or

1 professionalism or wait time issues with
2 customers, those types of things?

3 A. No. I just said I'm aware of my
4 retail index score because that is sent to me on
5 a weekly basis, along with a number of surveys,
6 but I'm not aware of any of those breakdowns
7 that you mentioned.

8 Q. Okay. Let's go next to -- I lost
9 the page numbering. This page ends in Bates
10 number 929. At the top it says, "Pharmacy
11 Customer Service Scorecard."

12 MR. MAZGAJ: Objection;
13 foundation.

14 A. Hold on. I am --

15 Q. I've got a different page up. My
16 mine ends in 11929 in the same document.

17 MR. MAZGAJ: Right.

18 Same objection.

19 Q. Ms. Mooney, are you looking at a
20 page that says, "Pharmacy Customer Service
21 Scorecard" at the top and it's a horizontal --

22 A. I don't -- I don't know where
23 you're at. I have a 11929. In what tab are you
24 at? I don't --

1 Q. Same one. Tab --

2 A. 16?

3 Q. Tab 16, yes.

4 A. Ending in 11929, I have

5 "Bencivengo VOC" at the top.

6 MR. MAZGAJ: Yeah, it appears
7 there's a number of 11929s, four pages.

8 MR. GADDY: Oh. Sorry, Matt.
9 It's an Excel, so it's got the same
10 Bates number on it over and over again.

11 MR. MAZGAJ: Got it. Got it. Got
12 it. That's going to be tough.

13 MR. GADDY: Yeah.

14 MR. MAZGAJ: It looks like it's
15 about, I would say, 20 pages in.

16 A. Okay. So I see a bunch of
17 Pharmacy Customer Service scorecards, but what
18 am I looking at?

19 Q. So I'm looking at the one that's
20 for your particular store, 6377, which is about
21 the one, two, three, four -- it should be the
22 fifth page in.

23 A. Okay.

24 Q. I want to make sure we're looking

1 at the same thing. At the top in red it says,
2 "Pharmacy Customer Service Scorecard." Below
3 that, it says, "Negative Customer Service
4 Incidents."

5 Is that what you're looking at?

6 A. Right.

7 Q. Okay. And then on the left-hand
8 side of the page at the top, it says, "Week
9 Ending 6/6/2015."

10 Correct?

11 A. Yes.

12 Q. Okay. And then the left -- the
13 far left-hand column is Rx number, and about
14 two-thirds, three-fourths of the way down the
15 page, there's an entry for 6377, which is you,
16 right?

17 A. Right.

18 MR. MAZGAJ: Object to foundation
19 and the document.

20 Q. Is this a -- do you see or receive
21 this pharmacy customer service scorecard?

22 A. Yeah, I think these get sent.

23 But, I mean, I don't -- like I said, other than
24 the number and the fact that the incidents come

1 to me separately, I don't really -- I don't
2 really look at these.

3 Q. Okay. But my question is simply
4 whether or not these are sent to you so that you
5 have the opportunity to look at them if you'd
6 like to.

7 A. I mean, I've seen one before, but
8 I don't know with what -- how often these are
9 sent to me. I don't. I honestly -- they're so
10 hard to read. I -- yeah, I've seen them, but I
11 don't know when they're sent.

12 Q. Okay. And it looks -- if you look
13 at the first couple of entries, there's an entry
14 for the "Store Segmentation," and it's either
15 signature or traditional.

16 What's the difference there?

17 A. I have no idea.

18 MR. MAZGAJ: Objection;
19 foundation.

20 Q. Okay. And then it -- there's an
21 entry for "PDL," and you told us that Angie was
22 your PDL for a period of time, correct?

23 A. Yes, Angela was.

24 MR. MAZGAJ: Objection to form.

1 Q. Okay. And then there's -- it
2 looks like in pink at the top, there's entries
3 for any negative customer service incidents that
4 have occurred during the current week.

5 Do you see that?

6 MR. MAZGAJ: Objection;
7 foundation.

8 A. Yes, I can see that.

9 Q. Okay. And it looks like there's
10 potential entries for -- you know, the second
11 one is related to HIPAA privacy issues, correct?

12 MR. MAZGAJ: Objection;
13 foundation.

14 A. Okay. Yes.

15 Q. There's an entry for pricing for
16 the prescription.

17 Do you see that?

18 MR. MAZGAJ: Same objection.

19 A. Yes.

20 Q. Next to that there's an entry for
21 any negative customer service incidents
22 regarding promise time for a prescription.

23 Do you see that?

24 MR. MAZGAJ: Objection.

1 A. Okay.

2 Q. Do you see that?

3 A. Yes.

4 Q. Okay. If we go down a couple, do
5 you see towards the end of the pink section,
6 there's an entry for whether or not there were
7 any complaints regarding the wait time for a
8 prescription?

9 A. Okay.

10 MR. MAZGAJ: Same objection.

11 Q. Do you see that?

12 A. I do.

13 Q. And then if you go over and look
14 in the blue section, do you see that they
15 have -- it kind of looks like it's the same
16 entries and just asking how many complaints or
17 negative customer service incidents there have
18 been year to date for all of these things,
19 including the pricing issue, the promise time,
20 the wait time for a prescription, and those
21 types of things.

22 Do you see that?

23 MR. MAZGAJ: Objection;
24 foundation.

1 A. Yes.

2 Q. And I think you told us earlier
3 that one of the things you focus on when you
4 receive feedback from corporate, it would be
5 issues related to customer complaints, and
6 you're wanting to make sure that you're aware of
7 these issues and you have the opportunity to
8 talk to your team members and the customers
9 about any of those issues, right?

10 MR. MAZGAJ: Objection; misstates
11 the testimony.

12 A. Yes. As a complaint, yes. I
13 mean, they use a different avenue to do that.
14 So when I actually receive a complaint, I can
15 deal with that.

16 MR. MAZGAJ: Mr. Videographer, can
17 we get a run time?

18 THE VIDEOGRAPHER: 6 hours, 37
19 minutes, Counsel.

20 MR. MAZGAJ: Thank you.

21 BY MR. GADDY:

22 Q. Okay. If you keep flipping past
23 the pages of pharmacy customer service
24 scorecard, you'll get to another spreadsheet

1 that starts. And it has two charts, one on --
2 two charts on the page, one with a blue heading
3 and one with an orange heading.

4 MR. MAZGAJ: May I renew my
5 objection based on foundation. You
6 haven't established that she's ever seen
7 any of these documents, and she's here
8 in her individual capacity.

9 Q. Let me know, Ms. Mooney, when you
10 find that next type of chart.

11 A. Yes. I see the chart.

12 Q. Okay. And, again, I want to look
13 at the results for your store. So one, two,
14 three, four -- it's the fifth page in.

15 A. Right. I see it.

16 Q. Okay. And you see that it -- at
17 the top of the one that I'm looking at, it says,
18 "Comparison 6/29/14 through 6/6/15."

19 Do you see that at the top?

20 A. Yes.

21 Q. And do you see about three-fourths
22 of the way down, there's an entry for store
23 6377.

24 Do you see that?

1 A. Uh-huh. Yes.

2 Q. Okay. Do you recognize this
3 chart? Is this information that you were
4 provided by either your PDL or anybody else at
5 Giant Eagle?

6 A. Like I said before, I could have
7 had this sent to me, but I just look at a -- at
8 the score and take it for what it is, a score.
9 And then I deal with negative and positive
10 complaints separately when they come through via
11 e-mail. So, again, I don't really look at
12 these.

13 Q. Okay. But these are examples of
14 the pharmacy customer service index scores that
15 you were sent, and then obviously you can
16 determine to do whatever you want with it.

17 Is that fair?

18 A. I can determine that I don't
19 really look at them, yes, for that.

20 Q. Okay. After you get them, there's
21 no requirement from corporate that you do
22 anything with them? You've got them. You can
23 do with them what you want, correct?

24 A. Right. It's a score, a value

1 assigned.

2 Q. Okay. And if we look at your row
3 for 6377 on this particular report, again, it
4 has your PDL listed there as Angela. It has the
5 count as far as the number of surveys that were
6 done. It indicates your overall score at
7 78 percent.

8 Do you see that? Are you tracking
9 with me?

10 A. Yes. I'm reading that.

11 Q. Okay. And then as far as some of
12 the other information that it provides, it has
13 an overall -- it has the overall satisfaction
14 score of 78 percent out of 104 respondents. And
15 then there's a satisfaction score of 75 percent
16 as it relates to time to fill a prescription
17 from an order based on 102 respondents.

18 Do you see that?

19 MR. MAZGAJ: Objection; assumes
20 facts not on the face of the document.

21 A. I see this. I'm reading this.
22 Yes.

23 Q. Okay. And what you've told us is
24 that you get this information and you see this

1 score, but it's not something that you do
2 anything with or focus on, fair?

3 A. Right. I never even have been
4 told of that score. It's not used in my
5 practice, so I don't know anything about that.

6 Q. Okay. And then the next thing
7 that you received is a score of 76 percent on
8 the issue of pharmacy team member friendliness
9 out of 104 responses.

10 Do you see that?

11 MR. MAZGAJ: Objection to form.

12 A. Again, I'm -- yes, I'm reading
13 that.

14 Q. Okay. And, again, these are
15 reports and scores that you get on a weekly
16 basis, I think you said, and then you either
17 disregard --

18 A. I didn't say weekly. I don't know
19 when I received these, but -- no, I did not say
20 weekly basis.

21 Q. Okay. I'm sorry.

22 Do you know how frequently you get
23 your scores and your performance on the customer
24 satisfaction surveys?

1 A. I -- like I said, I -- the overall
2 score gets sent to me weekly. These breakdowns,
3 I don't know. And if I have a negative
4 complaint, it is sent to me separately, and I
5 deal with those on an individual basis.

6 Those other scores have -- I mean,
7 I've been managing for years, and none of them
8 have ever come up to me, so I don't -- I don't
9 look at these. So you can take that for what it
10 is.

11 Q. Okay.

12 A. I just see the original score.

13 Q. Okay. Well, and we can't really
14 say they never came up because we saw one year
15 that was one of the factors on which you were
16 evaluated on your annual performance review,
17 right?

18 A. Is the overall score.

19 Q. Okay.

20 A. Yeah.

21 Q. Well, specifically you were
22 evaluated on your performance on the time to
23 fill from order.

24 Do you recall that?

1 A. No.

2 MR. MAZGAJ: Objection to form.

3 Q. Okay. Would you just defer to the
4 evaluation document for whether or not you were
5 specifically evaluated on your store's
6 performance on the customer satisfaction survey
7 on the time to fill from an order?

8 MR. MAZGAJ: Objection to form.

9 A. I have never -- I have never been
10 evaluated on a time to fill. My overall score
11 is listed on there. I don't -- I don't know
12 anything about a time to fill score being on one
13 of my evaluations.

14 Q. Okay. Okay. Well, I knew I
15 didn't make up the weekly thing. So weekly you
16 get your overall score. And at some other
17 frequency, you get a more detailed report that
18 gives you your score in different areas.

19 Is that fair?

20 A. Sure.

21 Q. Okay. And you either look at it
22 or you don't. And I guess what you're telling
23 us is that you don't really pay it much
24 attention.

1 Is that fair?

2 A. Right.

3 MR. MAZGAJ: Objection to form.

4 A. And I don't get evaluated on my
5 time to fill score.

6 Q. Okay.

7 A. I have never been evaluated on a
8 time to fill score.

9 MR. GADDY: Thank you, Ms. Mooney.
10 I don't have any more questions for you
11 today.

12 THE WITNESS: Thank you.

13 MR. MAZGAJ: All right. I'm going
14 to have a little bit of -- a couple
15 questions, and for the sake of
16 everyone's Friday afternoon, I think
17 I'll just jump right into it.

18 - - -

19 REDIRECT EXAMINATION

20 BY MR. MAZGAJ:

21 Q. Ms. Mooney, can you please go to
22 tab 2, which I believe was marked as Exhibit 9.

23 Are you with me?

24 A. Yes.

1 Q. I think you referred to this
2 section of the Controlled Substance Dispensing
3 Guideline in your testimony, but we didn't walk
4 through it, so let's go to page 4 of that
5 document. And if you could just read that
6 paragraph for me real quick, and we'll talk
7 about it, out loud.

8 A. Okay. "Giant Eagle supports the
9 professional judgment of each pharmacy team
10 member. If after performing required due
11 diligence and in the exercise of his or her
12 professional judgment, a pharmacist determines
13 that a prescription should not be filled, Giant
14 Eagle will support the decision. No team member
15 may try to coerce a Giant Eagle pharmacist to
16 fill a prescription that in his or her
17 professional judgment and after appropriate
18 investigation should not be filled. Any
19 coercion will be considered an ethics violation
20 and will be reported and disciplined according
21 to the Giant Eagle code of ethics."

22 Q. Okay. And then just generally,
23 has this been your experience while working for
24 Giant Eagle?

1 A. Yes, completely. I have the full
2 support of the company for my expertise as a
3 pharmacist. I think it shows in the fact that I
4 have worked for Giant Eagle my entire career,
5 that they have the same morals, ethics that I
6 do, and I wouldn't -- I couldn't morally,
7 ethically, legally work for a company that does
8 not share those values.

9 Q. So as far as values, what do you
10 mean by that? What's kind of the core value
11 that drives your practice?

12 A. Solely, I want to help people. I
13 do. I've always been that way. I have a family
14 of three girls, and I want to show my girls that
15 you're supposed to do the right thing and help
16 people. And fortunately I have a job that I can
17 do that in, and I can show them how important
18 that is for them as they grow.

19 Q. And so helping -- and I'm going to
20 combine two things here. I think that you
21 testified correctly that you assess each
22 prescription of each patient individually; is
23 that accurate?

24 A. I do. Yes.

1 Q. Okay.

2 A. I take many things into account.

3 Q. So when you're helping individual
4 people, why is it important to treat each
5 patient and each prescription individually?

6 A. I'm not a robot. I am a
7 professional with a degree, with a license. And
8 I think I owe it to every patient to give them
9 and give their prescription my full attention
10 and my expertise so that they get the
11 prescription, the dose that they need, and come
12 back for that reason, is to keep them safe.

13 Q. Yeah, and so I guess as a general
14 matter, you would never fill a prescription that
15 you didn't think was safe?

16 A. Never.

17 Q. Okay. And another word that you
18 said in there was "license." Is it my -- is it
19 correct that any individual prescribing a
20 prescription, especially an opioid, must have a
21 license to do so?

22 A. Yes. They would need a license to
23 do so.

24 Q. Okay. So you only distribute --

1 or dispense opioid medications that are written
2 by someone who is licensed to do so?

3 A. Correct.

4 Q. And that goes back to the DEA
5 number being required, and you're checking to
6 make sure that they are a licensed and active
7 medical professional; is that correct?

8 A. Yes.

9 Q. Okay. So back to Exhibit 9 again.
10 So we go through, and you talked about
11 performing due diligence. You have the support
12 of Giant Eagle.

13 The next part is about, "No team
14 member may coerce a Giant Eagle pharmacist to
15 fill a prescription that in his or her
16 professional judgment and after appropriate
17 investigation should not be filled."

18 Has anyone ever coerced you into
19 filling a prescription that you didn't think was
20 appropriate?

21 A. No.

22 Q. Now, if a customer comes in and
23 complains about you not filling an opioid
24 prescription, does that change your evaluation

1 of an individual prescription?

2 A. No. No. They --

3 Q. How do you treat -- we just went
4 over for a while the customer surveys. We --
5 you touched on it a little bit, that you would
6 address individualized negative -- or negative
7 reports.

8 Can you walk us through how that
9 might look?

10 A. If a negative or customer
11 complaint comes into the pharmacy, it would come
12 through as an e-mail with -- from a customer
13 care agent, someone -- like a 1-800 number that
14 they would call and put a complaint in. They
15 document that complaint and then send it to the
16 pharmacy with the patient's info.

17 So then I can read through the
18 complaint, associate what's going on to that
19 complaint, and then deal with -- deal with that
20 complaint, calling the customer back, seeing if
21 we can make something right, re-teaching to
22 employees.

23 Q. So I take it that you take
24 customer complaints very seriously; is that

1 true?

2 A. I do. Yes.

3 Q. But would a customer complaint
4 ever change your professional judgment and cause
5 you to change a decision on an opiate
6 prescription?

7 A. No.

8 Q. Okay.

9 A. No.

10 Q. We talked -- or you talked a bit
11 today about your bonus. I want to talk about
12 that briefly. And I guess the financials of
13 Giant Eagle in general.

14 Has anyone ever told you, Emily
15 Mooney, that the Painesville pharmacy needs to
16 make more money?

17 A. Never.

18 Q. Have you been told to -- well, let
19 me do it this way. Have you been told that you
20 need to sell more scripts?

21 A. Never.

22 Q. How would you do that if -- even
23 if they told you you had to sell more
24 prescriptions, how do you do that? Do you have

1 a marketing budget?

2 A. No, I do not. I don't know how to
3 do that. In those reports -- or for my review
4 at the end of the year, my PDL will give me that
5 information to fill in on my report. But for
6 the most part, I don't know, and I'm not
7 involved in that portion. I'm given a number,
8 and that's what I put into my report.

9 Q. Right.

10 A. And that's the extent of it.

11 Q. So the insinuation earlier seemed
12 to be that in order to fill more prescriptions,
13 you would have to -- or you could be motivated
14 to fill more prescriptions by ignoring red flags
15 or filling improper prescriptions.

16 Does that -- is that something
17 that you've ever seen at Giant Eagle?

18 MR. GADDY: Objection to form.

19 A. No, I've never -- I've never seen
20 that. I've never been asked to fill more, and
21 I've never been told to fill something that I
22 did not feel comfortable in filling, so ...

23 Q. Okay. So I didn't want to use the
24 document, but please go to tab 17. And I won't

1 go through all of these, but this was marked as
2 Exhibit 5.

3 And you recall reviewing the Giant
4 Eagle Bonus 2015 Pharmacy document with counsel
5 earlier?

6 A. Yes.

7 Q. Okay. So before we get into that,
8 do you know how much your bonus is?

9 A. It's roughly about \$6,000 a year,
10 give or take, and depending on the year.

11 Q. Okay. And let me just ask you
12 point-blank whether you would do anything to
13 jeopardize your license for that amount of
14 money?

15 A. Absolutely not. I would not.

16 Q. Would you -- would you fill
17 illegitimate prescriptions in order to receive
18 approximately \$6,000 a year?

19 A. No, I would not.

20 Q. And how about this: If Giant
21 Eagle found out that you were filling
22 illegitimate prescriptions, what would they do?

23 MR. GADDY: Objection to form.

24 A. They would terminate my

1 employment.

2 Q. Okay. So on this Exhibit 5, Giant
3 Eagle's Bonus 2015 Pharmacy, there's only one
4 take-home that I want to try and figure out.

5 Is the bonus available under this
6 policy unlimited?

7 A. No. I think it caps out at a
8 certain amount.

9 Q. Okay. Right. So there isn't --
10 it isn't an unlimited amount of bonus that you
11 can receive. There is a small percentage of
12 your overall salary that is available even if
13 you hit these metrics; is that right?

14 A. Right. That's my understanding.

15 Q. Okay. Let's see. Let's go to
16 tab 6.

17 Are you with me?

18 A. Uh-huh.

19 Q. I believe this is Exhibit 1.

20 Have you ever seen this document
21 before?

22 A. No, I have not.

23 Q. So do you know when it was
24 published or disseminated?

1 A. No, I do not.

2 Q. Okay. Go to tab 7, please.

3 A. Okay.

4 Q. I have this down as Exhibit 8.

5 Have you seen this document
6 before?

7 A. No, I have not.

8 Q. Do you know when it was published
9 or disseminated?

10 A. No, I do not.

11 MR. MAZGAJ: Okay. That's all I
12 have.

13 Thank you, Ms. Mooney.

14 - - -

15 RECROSS-EXAMINATION

16 BY MR. GADDY:

17 Q. Ms. Mooney, real quick. Your
18 counsel asked you about the fact that all the
19 prescriptions for opiates that are presented to
20 you have been written by a licensed physician.

21 Do you recall that?

22 A. Yes, I do.

23 Q. Okay. Despite the fact that
24 you're presented with prescriptions written by

1 licensed doctors, you've still had the occasion
2 to determine that some of those prescriptions
3 were not appropriate to be filled, and you have,
4 in fact, refused to fill some of those
5 prescriptions on occasion, correct?

6 A. Yes, for reasons talked about
7 earlier. Yes. There's still prescriptions that
8 I wouldn't fill.

9 MR. GADDY: Thank you, Ms. Mooney.
10 That's all I have.

11 THE VIDEOGRAPHER: Off the record,
12 6:07 p.m.

13 (Signature reserved.)

14 - - -

15 Thereupon, at 6:07 p.m., on Friday,
16 April 16, 2021, the deposition was concluded.

17 - - -

18

19

20

21

22

23

24

CERTIFICATION

I, Carol A. Kirk, Registered Merit Reporter and Certified Shorthand Reporter, do hereby certify that prior to the commencement of the examination, EMILY MOONEY was duly remotely sworn by me to testify to the truth, the whole truth, and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a verbatim transcript of the testimony as taken stenographically by me at the time, place, and on the date hereinbefore set forth, to the best of my ability.

I DO FURTHER CERTIFY that I am neither a relative nor an employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.



Carol A. Kirk, RMR, CSR

Notary Public

Dated: April 21, 2021

1 DEPOSITION ERRATA SHEET

2

3

4 Case Caption: National Prescription Opiate Litigation
County of Lake, Ohio v. Purdue
5 County of Trumbull, Ohio v. Purdue

6

7 DECLARATION UNDER PENALTY OF PERJURY

8

9 I declare under penalty of perjury that I
10 have read the entire transcript of my deposition taken
11 in the captioned matter or the same has been read to
12 me, and the same is true and accurate, save and except
13 for changes and/or corrections, if any, as indicated
14 by me on the DEPOSITION ERRATA SHEET hereof, with the
15 understanding that I offer these changes as if still
16 under oath.

17

18

EMILY MOONEY

19

20 SUBSCRIBED AND SWORN TO

21 before me this _____ day

22 of _____, A.D. 20____

23

24

Notary Public

1	DEPOSITION ERRATA SHEET
2	Page No.____Line No.____Change to:_____
3	_____
4	Reason for change:_____
5	Page No.____Line No.____Change to:_____
6	_____
7	Reason for change:_____
8	Page No.____Line No.____Change to:_____
9	_____
10	Reason for change:_____
11	Page No.____Line No.____Change to:_____
12	_____
13	Reason for change:_____
14	Page No.____Line No.____Change to:_____
15	_____
16	Reason for change:_____
17	Page No.____Line No.____Change to:_____
18	_____
19	Reason for change:_____
20	Page No.____Line No.____Change to:_____
21	_____
22	Reason for change:_____
23	
	SIGNATURE_____DATE:_____
24	EMILY MOONEY

1	DEPOSITION ERRATA SHEET
2	Page No._____Line No.____Change to:_____
3	_____
4	Reason for change:_____
5	Page No._____Line No.____Change to:_____
6	_____
7	Reason for change:_____
8	Page No._____Line No.____Change to:_____
9	_____
10	Reason for change:_____
11	Page No._____Line No.____Change to:_____
12	_____
13	Reason for change:_____
14	Page No._____Line No.____Change to:_____
15	_____
16	Reason for change:_____
17	Page No._____Line No.____Change to:_____
18	_____
19	Reason for change:_____
20	Page No._____Line No.____Change to:_____
21	_____
22	Reason for change:_____
23	
	SIGNATURE_____DATE:_____
24	EMILY MOONEY